

237152

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY E. LAST ABEL		2a. DATE OF DEATH MONTH 8 DAY 15 YEAR 85		2b. HOUR 1235 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 12 DAY 22 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. STATE Maryland	13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Unknown MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-74-4754		17. INFORMANT Glen Burnie, Md. 21061
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRO-VASCULAR ACCIDENT</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>PNEUMONIA</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from <u>8/8/85</u> to <u>8/15/85</u> , that (2) we lost saw the deceased <u>above</u> , (3) (we) (did not) view the body after death.		
22b. SIGNATURE <u>Dr. Zimmerman</u>		22c. DATE SIGNED <u>8/15/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ZIMMERMAN
22e. ADDRESS 200 Hospital Dr. Glen Burnie, Md. 21061		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		
23b. DATE 8/17/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery Baltimore, Md. 21222		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR Raymond C. Fink Funeral Home		
25a. DATE REC'D. BY REGISTRAR AUG 16 1985		25b. REGISTRAR'S SIGNATURE <u>J. H. Davidson</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove (detach) pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

240085

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LAST ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 8-22-85		2b. HOUR 8:35 AM									
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.								
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY household						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Galesville						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 991 Galesville Rd. 20763						
14. FATHER'S NAME FIRST M. MIDDLE LAST Dorsey			15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE LAST Alden											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 578-44-1336			17. INFORMANT Helen Orme			ADDRESS 1024 Carrs Wharf Rd. Edgewater Md. 21037					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) stroke DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 8-20, 1985, to 8-22, 1985, that (I) (we) lost saw the deceased alive on 8-21, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Julie Buchanan						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-22-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julie Buchanan						22e. ADDRESS 4131 Shady Side Rd. Shady Side MD 20764								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/26/85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.						
24. FUNERAL DIRECTOR (NAME) Hardesty Funeral Home						12 Ridgely Ave. Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR AUG 26 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

9/9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) BERNARD CLIFTON ALLEN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 1, 1985		2b. HOUR 437 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 10 1910		
6. AGE (IN YEARS (LAST BIRTHDAY)) 75		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1318 Yorktown Rd. 21401				
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD ALLEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH PORTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-0650		17. INFORMANT ADDRESS Annapolis, Md. 21401 NOLA MITCHELL Log Inn Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction with DUE TO, OR AS A CONSEQUENCE OF Recurrent myocardial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last infarction DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent myocardial (c) infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Coronary atherosclerosis Paul DeSim						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 7/3/85 to 8/1/85 that (I) (we) last saw the deceased alive on 7/3/85 and that in my (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (do) (did) not know the body after death.						
22a. SIGNATURE Anastacio E. Subong, M.D.		22b. ADDRESS 206 CRAIN HIGHWAY S.W. GLEN BURNIE, MARYLAND 21061		22c. DATE SIGNED 8/1/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-6-1985		23c. NAME OF CEMETERY OR CREMATORY ASBURY BROADNECK CEME.		
23d. LOCATION CITY OR TOWN COUNTY STATE St. Margarets A.A. Maryland		23e. DATE REC'D. BY REGISTRAR AUG 7 1985				
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A.		25. REGISTRAR'S SIGNATURE Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

237 0121

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730-274-13

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARLTON R. ALLENDER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 27, 1985		2b. HOUR P. M. 12:00		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 20 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Allender		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gorda Fike		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 232-10-3999		17. INFORMANT ADDRESS R. Bruce Allender 7801 York Rd Towson, Md 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic CA lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18a old Myocardial Infarction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE [Signature]		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHADELWAL, M.D.		22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/30/85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy Balto Md				25a. DATE REC'D. BY REGISTRAR AUG 29 1985			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from file and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE [illegible] BY [illegible]

EX-100

100-100

100-100

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE [illegible] BY [illegible]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

234130

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Joy Ellen Auman				August 15, 1985 4:30P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
female		white		July 29 1955		30 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Florida		U.S.A.				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		704 Marlboro Road		Artist		Frame Shop	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
Maryland		Anne Arundel		Glen Burnie		704 Marlboro Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Robert L. Auman				Thelma E. Sirmans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Mother) ADDRESS			
No		N/A		Mrs. Thelma E. Auman Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Cervical Cancer							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
NA							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, WAR, UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFIED DEATH EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN				22c. ADDRESS		22d. DATE SIGNED	
Neil Grossenshein MD				The Johns Hopkins University		8/16/85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS			
Neil Grossenshein				The Johns Hopkins University			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		August 19, 1985		Meadowridge Mem. Park		Elkridge Howard Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Singleton Funeral Home, Glen Burnie, Maryland				AUG 20 1985		John Burdson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "notified," item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20% COTTON FIBER

DAVIDSON POWER



.. Park

232121

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Naomi Marie Averill			2a. DATE KNOWN OF DEATH ESTIMATED Aug 10, 1985			2b. HOUR P. M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1915	6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Aug 10, 1985	7d. HOUR P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 670 Americana Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Public Works	
13a. STATE MD		13b. COUNTY A. A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 670 Americana Drive		13f. CITY OR TOWN Annapolis		13g. STREET ADDRESS 21403		13h. CITY OR TOWN Annapolis		
14. FATHER'S NAME FIRST MIDDLE LAST William Charles Benning			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgetta Louis Deale			16. SOCIAL SECURITY NO. 219-16-2737		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-16-2737			17. INFORMANT Constance B. Tollerik		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) A.S.C. V.D. DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones MD			TITLE (SPECIFY) Registery			DATE SIGNED 12 Aug 85		
EXAMINER'S NAME (TYPE OR PRINT) WM. P. Jones MD			ADDRESS 2444 Solomons Isl. Rd Edgewater			STATE MD		
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE Aug 13, 1985			23c. NAME OF CEMETERY OR CREMATORY St. Anne's		
23d. LOCATION CITY OR TOWN Annapolis			COUNTY AA			STATE MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 16 1985		
25b. REGISTRAR'S SIGNATURE John Davidson-Randall								

MEDICAL CERTIFICATION

252083

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Anna OSHEA Baldwin		MONTH DAY YEAR 8 30 1985		10 45 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
FEMALE	WHITE	MONTH DAY YEAR JAN 21 1900		85	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
NEW JERSEY	USA			ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	H.A. GENERAL Hospt.		TEACHER		Public Schools
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
NEW JERSEY	Hudson	Jersey City	13e. STREET ADDRESS / ZIP CODE 323 UNION ST. 07304		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Patrick OSHEA		Margaret Moriarty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO				DONALD B. ALLEN 539 POWELL DR. ANNAPOLIS MD. 21401	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert M. Greenfield M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Greenfield, M.D.				22e. ADDRESS 137 Old Solomon's Isl Road			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	9/5/85	Holy NAME Cent.	Jersey City Hudson N.J.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Taylor Funeral Chapel		SEP 5 1985	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

54085

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242115

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) GEORGE MONROE BALDWIN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 20, 1985			2b. HOUR 9:40 AM			
3 SEX M		4 RACE C		5. DATE OF BIRTH MONTH DAY YEAR 7-13-97		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md.			13b. COUNTY A.A.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Thomas Baldwin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Manie Barnsley			13e. STREET ADDRESS / ZIP CODE 1320 St. Stephens Church Rd. 21032			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-36-3453		17. INFORMANT ADDRESS Roland Baldwin Rd. Crownsville Md. 1350 St. Stephens Church				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 8-10-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dysphagia, Malnutrition		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-30-1985 to 8-20-1985 that (I) (we) last saw the deceased alive on 8-19-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE U. R. Sunkara		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U. RAO SUNKARA, M.D.		22e. ADDRESS 14 WELLHAM AVENUE #203 GLEN BURNIE, MD 21230					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-22-85		23c. NAME OF CEMETERY OR CREMATORY Mt. OAK		23d. LOCATION CITY OR TOWN COUNTY STATE Mitchellville e Md.	
24. FUNERAL DIRECTOR NAME T.A. Hardesty				ADDRESS Annapolis, Md. 21401		25a. DATE REC'D. BY REGISTRAR AUG 26 1985	
25b. REGISTRAR'S SIGNATURE J. Davidson							

MEDICAL CERTIFICATION

1915

DOWN

WATER

DOWN

WATER

PLS

ALP

252061

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETTY B. BASIL		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 23, 1985		2b. HOUR 5:40PM	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH FEBRUARY 21, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12. USUAL OCCUPATION (IF DECEASED WAS NOT WORKING, GIVE LAST OCCUPATION) ADMINISTRATIVE ASSISTANT		13. KIND OF BUSINESS OR INDUSTRY NAVAL ACADEMY
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME CHARLES BROOKS		15. MOTHER'S MAIDEN NAME ELIZABETH HIPKINS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-05-0236		17. INFORMANT ADDRESS OWEN A. BASIL, SR. SAME AS 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Stanley P. Watkins Jr.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS Jr.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8-26-85		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF	
23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS ANNE ARUNDEL CO. MD.		23e. DATE REC'D. BY REGISTRAR SEP 5 1985			
24. FUNERAL DIRECTOR ROBERT E. EVANS ANNAPOLIS, MARYLAND		25. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove container labels, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

180075

TO THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
FROM THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

226085

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1 DECEASED NAME (TYPE OR PRINT) ORMA ARTELLE BEHRENDT			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 8, 1985			2b. HOUR MIN. 419 PM			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 1, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN MILLERSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM WESTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OSHIE JACKSON			13e STREET ADDRESS / ZIP CODE 237 WEST PASADENA ROAD 21108			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (HUSBAND) WILLIAM K. BEHRENDT		ADDRESS SAME AS #13			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

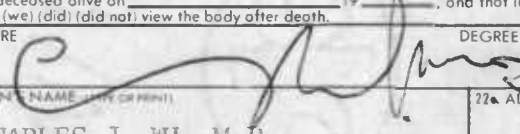
DUE TO, OR AS A CONSEQUENCE OF

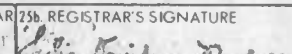
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 8</u> 19 <u>85</u> to <u>Aug 8</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Aug. 8, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D.		22e. ADDRESS GLEN BURNIE, MARYLAND 21061					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 12, 1985		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.	
24 FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u> ADDRESS <u>GLEN BURNIE, MD 21061</u>				25a. DATE REC'D. BY REGISTRAR AUG 9 1985		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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Reserve cordage and rope
and more reserve
dix

10-12-1941

10-12-1941



COLOMBIA

07/84
25M[illegible]

BP_____

DHMH - 17

(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 1 3 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
WILLIAM		W.		BELT		8		21		1985		9:38 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
Male		Caucasian		June 10, 1936		49 YRS.		MONTHS		DAYS		8 21 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Michigan		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						U.S.	
Annapolis		Anne Arundel General Hosp.		Defense Analyst		Government							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Montgomery		Rockville		X		601 Ivy League Lane 20850					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST			
John		West		Belt		Margorie				Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		Korea		577-48-0989		Catherine R. Belt (wife) Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b) _____		DUE TO, OR AS A CONSEQUENCE OF									
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. <u>Acting Chief</u>		MEDICAL EXAMINER		DATE SIGNED		8-22-85					
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		August 26, 1985		Arlington National Cemetery		Arlington Virginia							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland		AUG 28 1985											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence M. Beron			2a. DATE OF DEATH MONTH DAY YEAR 08-07-85		2b. HOUR 3:56 PM				
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03-11-98		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND						13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PARK	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW D. UBER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN HARGROVE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 206-28-9059		17. INFORMANT DAVID BERON		ADDRESS (SAME AS 13)			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMID	
DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE PNEUMONIA		24 HRS	
DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE PARKINSON'S DISEASE		10 YRS	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from **July 7**, 19 **85**, to **Aug 7**, 19 **85**, that (I) (we) last saw the deceased alive on **Aug 7**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE John D. Jackson		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-7-85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. JACKSON				22e. ADDRESS 1833 FOREST DR., ANNAPOLIS, MD 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 12, 1985		23c. NAME OF CEMETERY OR CREMATORY WEST LAUREL HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALDWIN CYNWYD MONTGOMERY PA	
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24. FUNERAL DIRECTOR NAME GILBERT H. SCHOBERT		ADDRESS 1677-79 HARRISON ST. PHILADELPHIA, PA.		25a. DATE REC'D. BY REGISTRAR AUG 12 1985		25b. REGISTRAR'S SIGNATURE John D. Jackson	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHARA D. BIGELOW			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1985			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 30, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 111 JackPine Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home-maker		12b. KIND OF BUSINESS OR INDUSTRY Home e	
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Oscar W. Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leah Wells			16. ADDRESS (21122)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 568-10-7205		17. INFORMANT ADDRESS Mr. Norman E. Bigelow, Jr. / 111 JackPine Dr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-16</u> , 19 <u>84</u> , to <u>8-21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8-1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8-21-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Long S. Hsu</u>			22e. ADDRESS <u>7845 Oakwood Rd. / Glen Burnie, Md. 21061</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Aug. 23, 85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CrestLawn Mem. Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Howard Co., Md.</u>		
24. FUNERAL DIRECTOR NAME <u>McGully Funeral Home/</u>			24b. DATE REC'D. BY REGISTRAR <u>AUG 26 1985</u>			24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24a. FUNERAL HOME <u>Mountain & Tick Neck Rds</u>			24b. ADDRESS <u>Pasadena, Md. 21122</u>						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200920



[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side. Some visible fragments include:]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>James W Bishop</i> SR.					2a. DATE OF DEATH MONTH DAY YEAR <i>8 20 85</i>		2b. HOUR <i>16</i> MIN <i>40</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 16 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL COUNTY</i> MD.					
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE ARUNDEL GENERAL HOSPITAL</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>EXECUTIVE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DRUG CO.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>ANNE ARUNDEL</i> 13c. CITY OR TOWN <i>ANNAPOLIS</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE <i>14 CARVEL DRIVE 21401</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>SAMUEL JAMES</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>EDNA BRITTINGHAM</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-03-4501</i>		17. INFORMANT ADDRESS <i>NAOMI R. BISHOP SAME AS 13E</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) <i>Cardiac Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Coronary Artery Disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive C-V. Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Renal failure.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10/9 19 85</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <i>10/9 19 85</i> to <i>8/20 85</i> , that (I) (we) lost saw the deceased alive on <i>5/20 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. Brimhall MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8/20/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RODNEY BRIMHALL MD</i>				22e. ADDRESS <i>1419 FOREST DR. ANNAPOLIS, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>8-23-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HILLCREST</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ANNAPOLIS A.A. CO. MD.</i>					
24. FUNERAL DIRECTOR <i>ROBERT E. EVANS ANNAPOLIS, MARYLAND</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN RANDOLPH BOYKIN, SR.			2a DATE OF DEATH MONTH DAY YEAR AUGUST 7, 1985		2b HOUR 6:30p _M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 24, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10 CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER (ret)		12b KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE MD.	13b COUNTY A.A.	13c CITY OR TOWN ARNOLD	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 182 DONCASTER RD. 21012	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIS O. BOYKIN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE SENSING		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A	17 INFORMANT (WIFE) ADDRESS MRS. JANE A. BOYKIN SAME AS #13		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 12/20/84, 19 to 5/29, 1985, that (1) (we) lost saw the deceased alive on 5/29/85, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b SIGNATURE P. RHODES				22c DATE SIGNED 8/9/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) P. RHODES				22e ADDRESS 1667 Crofton, Centre, Crofton, Md. 21114	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE AUG. 10, 1985	23c NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK	23d LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.
24 FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061		25a DATE REC'D. BY REGISTRAR AUG 9 1985	
25b REGISTRAR'S SIGNATURE Davidson-Rendell			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Thomas W. Bradley			8 22 85			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	7 29 17	68			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS.		
Maryland	U.S.A.		Anne Arundel			MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie	North Arundel Hospital		Superintendent			U.S. Postal Serv		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE				
Maryland	A.A.	Glen Burnie		8041 Stone Haven Drive 21061				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
Roland Bradley		Elizabeth Porter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes		WW II		Ruth E. Bradley Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Pulmonary embolus								
DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia, Ventricular								
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Cardiomyopathy								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus; A.S.D.V.D.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)				
22a. I certify that (I) (the hospital) attended the deceased from 8-1-80 to 22-Aug 85, that (I) (we) last saw the deceased alive on 22-Aug 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE		DEGREE		22c. DATE SIGNED				
Richard E. Fisher								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Richard E Fisher		4710 Pennington Ave						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)		
Burial		8/26/85		Cedar Hill Cem		Balto A.A. Md		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George J. Gonce 4001 Ritchie Hwy Balto Md				AUG 26 1985		R. J. Gonce		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES W. BRADY			2a. DATE OF DEATH MONTH DAY YEAR Aug. 27 1985		2b. HOUR 5:30 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 27 26		
6. AGE (IN YEARS, LAST BIRTHDAY) 58 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DISTRICT OF COLUMBIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		13. STREET ADDRESS / ZIP CODE 5963 FRANKLIN GIBSON RD / 20779		
14. STATE MD.		15. COUNTY ANN ARUNDEL		16. CITY OR TOWN TRACYS LANDING		
17. FATHER'S NAME FIRST MIDDLE LAST THOMAS - STURGES		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN CATHERINE KING		19. INFORMANT ADDRESS 5963 FRANKLIN GIBSON RD, TRACYS LANDING, MD 20779		
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		21. SOCIAL SECURITY NO. GEO. W. BRADY - RD, TRACYS LANDING, MD 20779		22. DATE SIGNED 8/28/85		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 79 to 8/27 19 85, that (I) (we) lost saw the deceased alive on 8/20 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE M.D.		22c. DATE SIGNED 8/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STUART E. SELONICK, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 51 Franklin St., Annapolis, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/30/85		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON (PAIGED'S) MD.	
24. FUNERAL DIRECTOR NAME Richard A. Coleman Fun'l Home - MD 20779		25a. DATE REC'D. BY REGISTRAR 8-29-85		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall		25c. REGISTRAR'S ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hazel Marie Briggs			2a. DATE OF DEATH MONTH DAY YEAR Aug. 13, 1985			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 26, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 925 Longview Dr. Pasadena, Md. 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Brenton - Gorsuch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura - Myers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - -		17. INFORMANT ADDRESS Mr. Charles Briggs, Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis & Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 hour</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jeffrey J. Coleman DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 8-14-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey F. Coleman						22e. ADDRESS 3455 Wilkens Ave. Baltimore, Md. 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gamber, Carroll Co., Maryland			
24. FUNERAL DIRECTOR NAME McCully Funeral Home, Mt. & Tickneck Rds.				24b. ADDRESS Pasadena, Md. 21122		24c. DATE REC'D. BY REGISTRAR AUG 16 1985		24d. REGISTRAR'S SIGNATURE John Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

232079

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				EDT			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME [TYPE OR PRINT] FIRST MIDDLE LAST CARL MNM O. BRIGHTFUL SR.				MONTH DAY YEAR AUGUST 12, 1985				926 AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 27 15		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7258 Furnace Branch Rd. 21061					
14. FATHER'S NAME FIRST MIDDLE LAST Oden Brightful				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Dunson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes				16b. SOCIAL SECURITY NO. 216-05-6978		17. INFORMANT ADDRESS Alice M. Brightful 7258 Furnace Branch Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> , 19 <u>85</u> , to <u>8/12</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Elliott Gorbaty</u> DEGREE				22c. DATE SIGNED <u>8/12/85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT GORBATY, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/16/85		23c. NAME OF CEMETERY OR CREMATORY Crownsville VA Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR AUG 15 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

7

249071

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21359

1. DECEASED NAME (TYPE OR PRINT) ARTHUR J BRINKLEY			2a. DATE OF DEATH MONTH 8 DAY 22 YEAR 85			2b. HOUR 1:30 P M											
3. SEX M		4. RACE N		5. DATE OF BIRTH MONTH 03 DAY 10 YEAR 44			6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.										
7a. BIRTHPLACE (COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.								
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD.						13b. CITY OR TOWN Traymsville			13c. STREET ADDRESS / ZIP CODE P.O. Box 29 21638								
14. FATHER'S NAME FIRST James MIDDLE E LAST Brinkley						15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Lewis LAST Lewis											
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) Viet						17. SOCIAL SECURITY NO. 219-42-8704						18. INFORMANT Mary Little					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF (b) Septic Thrombophlebitis, L arm DUE TO, OR AS A CONSEQUENCE OF (c) Cocaine abuse												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days - 6 days -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Staphylococcal septicemia -																	
19a. DATE OF OPERATION none				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> OFF WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from 8/22/85 to 8/22/85 , that (I) (we) lost saw the deceased alive on 8/22/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and not) view the body after death.																	
22b. SIGNATURE Richard N. Peeler								DEGREE				22c. DATE SIGNED 8/22/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD N. PEELER								22e. ADDRESS ANNAPOLIS MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/27/85		23c. NAME OF CEMETERY OR CREMATORY Robinson Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Grosmont MD							
24. FUNERAL DIRECTOR NAME George Dashiell								ADDRESS Easton Md.				25. DATE REC'D. BY REGISTRAR SEP 4 1985					

MEDICAL CERTIFICATION

219

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner or coroner must be notified.

BP

170000



248014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ella Mae Brown			2a. DATE OF DEATH MONTH DAY YEAR August 27, 1985		2b. HOUR 4:20P
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 13 1904	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.		
10. CITY OR TOWN OF DEATH SEVERNA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. PURCHASER	12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN HINTICUM HTS.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 503 KOCH ROAD, 21090
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WINNIE SMITH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 220-18-9896		17. INFORMANT ADDRESS WILLIAM R. BROWN, SR. SAME AS #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shonchopneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary heart failure

DUE TO, OR AS A CONSEQUENCE OF

(c) ALZHEIMERS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Urinary tract infection; Dehydration

19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERWAY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AS HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	

22a. I certify that (I) (this hospital) attended the deceased from May 27, 1985 to Aug. 27, 1985, that (I) (we) lost the deceased on Aug. 27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23. SIGNATURE <u>Benjamin de Guzman</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED MD 21061
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BENJAMIN DE GUZMAN	22e. ADDRESS 325 HOSPITAL DR. GLEN BURNIE	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8-29-85	23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS, INC	23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE, BALTO, MD.
24. FUNERAL DIRECTOR NAME McCULLY FUNERAL HOMES	ADDRESS 237 E. PATAPSCO AVE	25a. DATE REC'D. BY REGISTRAR AUG 30 1985	25b. REGISTRAR'S SIGNATURE <u>James W. Anderson-Randall</u>

1. The first section of the report deals with the general situation of the cotton industry in the United States. It is a very comprehensive and detailed account of the industry, covering the production, distribution, and consumption of cotton. The author provides a clear and concise summary of the industry's status, and the reader is able to gain a good understanding of the industry's structure and function.

2. The second section of the report deals with the economic situation of the cotton industry. It discusses the various factors that influence the industry's economic performance, such as the price of cotton, the cost of production, and the demand for cotton. The author provides a detailed analysis of these factors, and the reader is able to gain a good understanding of the industry's economic situation.

3. The third section of the report deals with the social situation of the cotton industry. It discusses the various factors that influence the industry's social performance, such as the working conditions of cotton workers, the impact of the industry on the environment, and the role of the industry in the community. The author provides a detailed analysis of these factors, and the reader is able to gain a good understanding of the industry's social situation.

4. The fourth section of the report deals with the future of the cotton industry. It discusses the various factors that will influence the industry's future, such as the technological advances in cotton production, the changing demand for cotton, and the impact of government policy on the industry. The author provides a detailed analysis of these factors, and the reader is able to gain a good understanding of the industry's future prospects.

WILSON
COTTON
FIELD

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		REG. NO.		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HEALTH	
HARRY		WILLIAM		BROWN						8		19		85				9/14/85	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		White		July 6 1931		54		MONTHS		DAYS		HOURS		MIN.		Y 20 19 85		0702	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
W.Va.				U.S.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Arundel							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Glen Burnie				North Arundel General Hospital				Engineer				Construction							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Penn.				Unknown				Granville				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Rt. 1, Box 136			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT			
James				Goldie				Yes				Korea				234-46-8226			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				20. DATE OF OPERATION				21. CONDITION FOR WHICH OPERATION WAS PERFORMED?				22. AUTOPSY?			
PART I DEATH WAS CAUSED BY:																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				(b)				DUE TO, OR AS A CONSEQUENCE OF											
								(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY			
								STREET								STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
James E. Wheeler, M.D.				1716 Gumbottom Road															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				CITY OR TOWN			
Burial				8-23-85				Pleasant View Mem. Gardens				Martinsburg				Berk. W.Va.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Douglas R. Browder				P.O. Box 388				18											
				Charles Town, W.Va.															

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1. 2003: 100%

continued

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Page 10 of 10

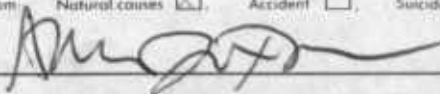
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221127

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST TERESA		MIDDLE S.		LAST BROWN		2a. DATE KNOWN OF DEATH		MONTH 8		DAY 1		YEAR 19 85		2b. HOUR M	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 4 DAY 4 YEAR 1957		6. AGE (IN YEARS) LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 8 DAY 1 YEAR 19 85		2d. HOUR 9A		M	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD											
10. CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2337 Weymouth Lane										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 41 Old Frederick Rd. 21012									
14. FATHER'S NAME FIRST ADAM		MIDDLE		LAST BROWN		15. MOTHER'S MAIDEN NAME FIRST GEORGIA MIDDLE Georgianna LAST PARKER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-70-3783		17. INFORMANT Arnold, Md. 21012 GEORGIANNA BROWN 41 Old Frederick Rd.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperthyroidism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 8-1-85					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-7-1985		23c. NAME OF CEMETERY OR CREMATORY ADAMS CHURCH CEMETERY		23d. LOCATION CITY OR TOWN Lothian A.A. Maryland											
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 7 1985 John E. Dixon															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR 20 YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP 264
DHMH - 17
(VR A15 ME (5))

225020

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REXFORD Albert BULL			2a DATE OF DEATH MONTH DAY YEAR 8-5-85			2b HOUR 11:00 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Rel. Stock Control Civil Service		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY A-A		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1535 Beach Drive 21403	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Bull				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iva Estep				ADDRESS same as #13	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1946		17 INFORMANT Janis Ann Brown		ADDRESS same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) unknown DUE TO, OR AS A CONSEQUENCE OF (c) unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DEMYELINATING SPINAL DIS. HEPATIC CIRRHOSIS; RENAL FAILURE									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 2-3-85 to 8-5-85 , that (I) (we) last saw the deceased alive on 8-5-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Edward S. Beck, MD						22c ADDRESS 1616 Forest Drive, Annapolis, MD		22d DATE SIGNED 8/5/85	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Aug 7, 1985		23c NAME OF CEMETERY OR CREMATORY Hillcrest		23d LOCATION CITY OR TOWN COUNTY STATE Annapolis A-A MD		
24 FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD						25a DATE REC'D. BY REGISTRAR AUG 8 1985		25b REGISTRAR'S SIGNATURE J. A. Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1945-1946

1947-1948



1949-1950

1951-1952

1953-1954

249104

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FDT

1. DECEASED NAME (TYPE OR PRINT) NORMA HENRIETTA BURCH			2a. DATE OF DEATH MONTH AUGUST DAY 30 YEAR 1985		2b. HOUR 040 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 8 DAY 23 YEAR 20	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist		12b. KIND OF BUSINESS OR INDUSTRY Steel
13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1607 Tleman Drive 21061
14. FATHER'S NAME FIRST Robert MIDDLE LAST Lilly		15. MOTHER'S MAIDEN NAME FIRST Amelia MIDDLE LAST Rosencrantz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-12-1328		17. INFORMANT ADDRESS Barron E. Burch Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic Breast CA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Removal of emboli					
19a. DATE OF OPERATION 8/20		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the decedent from 8/20 to 8/30 19 85 , that (1) (we) last saw the decedent alive on 8/29 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DAVID A. SCHWARTZ, M.D.					22c. DATE SIGNED 8/30/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. SCHWARTZ, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/3/85	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN BALTO COUNTY A.A. STATE MD		
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md			25a. DATE REC'D. BY REGISTRAR SEP 4 1985	25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Irene BURNHAM

2a. DATE OF DEATH MONTH DAY YEAR
August 22, 1985

2b. HOUR
2:55 P.M.

3. SEX
Female

4. RACE
Caucasian

5. DATE OF BIRTH MONTH DAY YEAR
Jan. 21, 1895

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
90

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD.

10. CITY OR TOWN OF DEATH
Annapolis

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Ann. Conv. Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife

12b. KIND OF BUSINESS OR INDUSTRY
household

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE
MD. A.A. Co. Edgewater 1906 Shore Dr. 21037

14. FATHER'S NAME FIRST MIDDLE LAST
Edward Henry

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Agnes Wood

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **no** 16b. SOCIAL SECURITY NO. **-----**

17. INFORMANT
**5907 Ridge Arthur Way
Mrs Emmans Glendale Md. 20769**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Inanition**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cerebral infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 months****6 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE

21g. WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

22a. I certify that (I) (this hospital) attended the deceased from **May 23, 1985** to **Aug. 22, 1985**, that (I) (we) last saw the deceased alive on **19**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **Charles W. Kinzer** DEGREE **ATTENDING PHYSICIAN** ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **Aug. 22, 1985**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **Charles W. Kinzer, M.D.** 22e. ADDRESS **16 Murray Ave., Annapolis, MD 21401**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b. DATE **8/24/85** 23c. NAME OF CEMETERY OR CREMATORY **Lakemont Cemetery** 23d. LOCATION CITY OR TOWN COUNTY STATE
Davidsonville A.A. Md.

24. FUNERAL DIRECTOR NAME **Hardesty Funeral Home** ADDRESS **12 Ridgely Ave. Ann. Md. 21401** 25a. DATE REC'D. BY REGISTRAR **AUG 26 1985** 25b. REGISTRAR'S SIGNATURE **John Burdson**



225021

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arthur Adrian Burns			2a. DATE OF DEATH MONTH Aug DAY 4 YEAR 1985			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Dec DAY 1 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 704 Fairway Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Civil Service	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 704 Fairway Drive 21401	
14. FATHER'S NAME FIRST Thomas MIDDLE LAST Burns			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 214-05-1488			17. INFORMANT Lillian W. Burns			ADDRESS Same as #13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) TERMINAL MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MW 1 YEAR 10 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 4/26 19 85 , to 8/4 19 85 , that (1) (we) last saw the deceased alive on 8/4 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Scott Eden, M.D.						DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT SCOTT EDEN, M.D.						22e. ADDRESS 703 GIDDINGS AVE. ANNAPOLIS, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 7, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD						25a. DATE REC'D. BY REGISTRAR AUG 8 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

241110

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21567

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST THELMA	MIDDLE ELLEN	LAST BUSSEY	2a. DATE OF DEATH MONTH DAY YEAR AUG. 25 85			2b. HOUR 1 A M		
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 11 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS			# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL CONV. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MD.						13b. COUNTY A.A.		13c. CITY OR TOWN SEVERN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ROME						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE WILSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT (SON) MR. RAYMOND W. BUSSEY SEVERN, MD.		ADDRESS 1064 LOVING RD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-16, 1985, to 8/25, 1985, that (I) (we) last saw the deceased alive on 8/25, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Karipineni		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANI S. KARIPINENI		22e. ADDRESS 200 Hospital Dr. Glenburnie					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1985 AUG. 28,		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.	
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME				ADDRESS GLEN BURNIE, MD		25a. DATE REC'D. BY REGISTRAR AUG 27 1985	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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227005

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Anthony		Carozza		August 8, 1985		4:44 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		July 2 1905		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Italy		U.S.A.				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hospital		Builder-Developer		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS			
Vincenzo Carozza		Assunta Carozza		2992 West Friends Rd. 21401			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		579-48-3827		Maria C. Volpe 430 N. Union St. Alexandria, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST							
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PARKINSONISM							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2/1/76, 1976, to 8/1/85, that (1) (the) lost saw the deceased alive on 8/1/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
[Signature]						8/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Garbus H. Nachmani, M.D.				8926 Woodyard Rd. Clinton, MD 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Entombment		8/12/85		Resurrection Cem. Mausoleum		Clinton P.G. Maryland	
24. FUNERAL DIRECTOR NAME				25a. REG. NO. 25b. REGISTRAR'S SIGNATURE			
George P. Kalas Funeral Home				6160 Oxon Hill Rd. Oxon Hill, Md. 15105			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Anthony	Carson	August 8, 1982 1:11 p
Male	Carson	80
Italy	X	anne anne
Annapolis	anne anne	Children-Deve of Construction
Maryland	Annapolis	2925 West Virginia Rd.
Vincennes	Carson	Carson
No	279-18-3827	180 W. Union St. Alexandria, Virginia

2014

George I. Kline Funeral Home
2150 Green Hill Rd.
Clinton 4.G. Maryland

Interment 8/12/82

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROOSEVELT		FIRST MIDDLE LAST CARR		2a. DATE OF DEATH MONTH DAY YEAR 8-12-85	2b. HOUR 2045 M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 07-12-10	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A.S.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1835 Bowman Dr. 21401
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CARR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUVENIA STEVENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 220-16-9187	17. INFORMANT ADDRESS EVA CARR 1835 Bowman Dr. Annapolis, Md. 21401			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Aug 12 , 19 85 , to Aug 12 , 19 85 , that (I) (we) lost saw the deceased alive on Aug 12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John D. Jackson	DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-12-85	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN JACKSON		22e. ADDRESS 1833 FOREST DR, Annapolis, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8-17-1985	23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A.			25a. DATE REC'D BY REGISTRAR AUG 19 1985		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes" shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

8-13-85
John D. Jackson, M.D.

SECRET

SECRET

SECRET

SECRET

SECRET, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100



61

246051

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Emmett Carroll			2a. DATE OF DEATH MONTH DAY YEAR August 27, 1985		2b. HOUR 1:15 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 23, 1920		
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.				
10. CITY OR TOWN OF DEATH Orchard Beach		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 218 Greenland Beach Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Petty Off.		
12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy						
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Orchard Beach		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 218 Greenland Beach Rd. 21226				
14. FATHER'S NAME James Ignatius Carroll		15. MOTHER'S MAIDEN NAME Margaret Mae Rogers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII Korea 213.16.6021		17. INFORMANT ADDRESS Esther B. Carroll (Wife) (Same as 13)		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS &</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE METASTASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>none</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>UNDER CONVALESCENCE</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> 19 <u>85</u> to <u>8/27</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>8/27/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRISON F. ARQUERNE		22e. ADDRESS 1940 W. Balt. St. Balt. Md 23				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/28/1985		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland						
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc., Dundalk, Md. 21222		25a. DATE REC'D. BY REGISTRAR AUG 28 1985				
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

246021



23/11/55

235153

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 21371

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter E Carroll			2a. DATE OF DEATH MONTH DAY YEAR August 16, 1985		2b. HOUR 10:55 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Athletic Director	12b. KIND OF BUSINESS OR INDUSTRY County School	
13a. STATE MD	13b. COUNTY AA	CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2003 Valley Road 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Patrick Carroll	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Newcomb		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR NAVY) Yes IWWII		
16b. SOCIAL SECURITY NO. 192-14-0868		17. INFORMANT Gloria Carroll -		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line. (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure & Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Arterial hypertension & Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a old CVA with Hemiparesis - Blind -					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (his hospital) attended the deceased from Aug 12, 1985, to August 16, 1985, that (I) (we) last saw the deceased alive on August 16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) (not) view the body after death.					
22b. SIGNATURE Gary M. Richardson, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary M. Richardson		22e. ADDRESS 104 Forbes Street Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 20, 1985	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR AUG 21 1985			

225022

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 50M 4/B2
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen K Christian			2a. DATE OF DEATH MONTH DAY YEAR HOUR MIN 8 6 85 6 45 M		
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 30 08	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Office Manager			
13a. STATE MD.		13b. COUNTY A.A.		13c. STREET ADDRESS FAIRFIELD Loop Rd. #1025	
14. FATHER'S NAME FIRST MIDDLE LAST Karl		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 276-18-8918		17. INFORMANT ADDRESS 1025 Harbor Dr. Annapolis, MD 21403	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 15 yr. DUE TO, OR AS A CONSEQUENCE OF (b) Seizure Disorder 5 yr. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from Sept 19 81, to Aug 19 85, that (I) (we) last saw the deceased alive on 16 Jul 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William P. Jones MD		DEGREE MD		22c. DATE SIGNED 8/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, M.D.		22e. ADDRESS 4837 Solomons Isl Rd. 20711			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/9/85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery Annapolis A.A. MD.	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR AUG 8 1985	
				25b. REGISTRAR'S SIGNATURE a Davidson-Rendell	

MEDICAL CERTIFICATION

[Faint handwritten notes]

248075

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) STANLEY JACOB CLARK			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 31, 1985		2b. HOUR 750 PM						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 14, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SIGN MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY STATE ROADS			
13a. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN SEVERN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1020 REECE ROAD 21144		
14. FATHER'S NAME FIRST MIDDLE LAST ASBURY CLARK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE RAY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 111111111		17. INFORMANT (NEPHEW) MR. NORMAN W. CLARK, Jr.		ADDRESS 1032 REECE RD SEVERN 21144					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION 8/31/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured aortic aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> 19 <u>85</u> to <u>8/31</u> 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>8/31</u> 19 <u>85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Arthur L. Gudwin			DEGREE M.D.			22c. DATE SIGNED 8/31/85			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. GUDWIN, M. D.		
22e. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPTEMBER 3, 1985			23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PK.			23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND		
24. FUNERAL DIRECTOR NAME ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD						25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as above.

BP

348078



RECEIVED
JAN 11 1961
LIBRARY

WILSON L. GORDON, JR.
1000 ATLANTIC HIGHWAY
SOUTH BEACH, OAKLAND 2100

246074

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ROLAND G COATES										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> Y 27 19 85 DAY <input type="checkbox"/> YEAR		2b. HOUR ? M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 1912		6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH Y 27 19 85 DAY YEAR		7d. HOUR 2240 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 432 Balto. Annapolis Blvd.					
14. FATHER'S NAME FIRST JOHN MIDDLE H. LAST COATES				15. MOTHER'S MAIDEN NAME FIRST LUVENIA MIDDLE WHITE LAST WHITE				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 214-05-2347		17. INFORMANT Severna Park, Md. 21146 CLARA DAY 906 Ritchie Highway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Resp. Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. COPD (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22b. TITLE (SPECIFY) D.P.					
ACTUAL SIGNATURE James E. Wheeler, M.D.				M.D. 1716 Gumbottom Road				DATE SIGNED 8-28-85							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS Crownsville 21032											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8-31-1985		23c. NAME OF CEMETERY OR CREMATORY CARPENTER HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Round Bay A.A. Maryland							
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. ADDRESS Annapolis, Md. 21401						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Solic Davidson-Randall							

BP

DHMH - 17
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20M 4/82

SECRET

WASHINGTON, D.C. 20540
OFFICE OF THE ATTORNEY GENERAL
U.S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE ATTORNEY GENERAL
SUBJECT: [Illegible]

DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

225014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT E dison CODY			AUGUST			5, 1985			900 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mainten. Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Gen. Re fract.				
13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8115 Armiger Dr. 21122			
14. FATHER'S NAME FIRST MIDDLE LAST William Louis Cody			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma - Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W 2		17. INFORMANT ADDRESS Janet Cody, same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary metastases DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of larynx										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 15 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of larynx				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 2 AUG 1985, to 5 AUG 1985, that (1) (we) lost saw the deceased alive on 5 AUG 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE James R. Appleton				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5 AUG 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. APPLETON, M.D., P.A.				22e. ADDRESS 310 CRAIN HIGHWAY, S.W. GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-9-1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md.						
24. FUNERAL DIRECTOR NAME ADDRESS McMully F. H. 3204 Mountain Rd. Pasadena, Md. 21122				25a. DATE REC'D. BY REGISTRAR AUG 8 1985		25b. REGISTRAR'S SIGNATURE						

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CHALK

20% COTTON



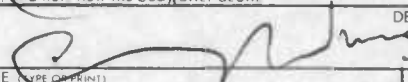
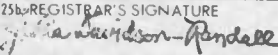
226036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

Y- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH E COUCH			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 5, 1985		2b. HOUR 240 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 13 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY A.A. Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Couch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-9451		17. INFORMANT ADDRESS Robert W. Couch Md 21122 215 Southwood Rd Pasadena		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laryngeal cancer with metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 4 19 85 to Aug 5 19 85 that (we) lost saw the deceased alive on Aug 4 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (we) did not view the body after death.					
22b. SIGNATURE 		DEGREE M.D.		22c. DATE SIGNED Aug 05 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WIL, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/7/85	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md			25a. DATE REC'D. BY REGISTRAR AUG 12 1985		
			25b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Handwritten text, possibly a date or initials.

246101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove棺盖 papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified above.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		21377		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
LILLIAN FRANCES CRAIG				8		27		85		2:06 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		BLACK		9 MONTH 9 DAY 09 YEAR		75		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARTIN ST., Md.		USA				BALTIMORE		AA				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		NORTH ARUNDEL GENERAL HOSP.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		1113 ASHBURTON ST.					
Md.				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
REV. ASBURY				WHITTINGTON		NETTIE		L.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				214-74-7284		RANDALL J. CRAIG		309 E. COLDSRING				LA	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>										Hours			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) <u>the</u> hospital attended the deceased from <u>7 Jan</u> 19 <u>85</u> to <u>27 Aug</u> 19 <u>85</u> , that (1) <u>was</u> lost saw the deceased alive on <u>28 June</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) <u>we</u> (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Charles R. Davidson				M.D.				28 Aug 85.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Charles R. Davidson, M.D.				2034 W. North Ave Baltimore Md 21217									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL				8-31-85		ARBUTUS MEM. PK.		BALTO.		MD.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE					
LEROY O. DYETT 4600 LIBERTY HGTS AVE.				AUG 29 1985				Julia Davidson-Randall					

101115



226033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		AUGUST 6, 1985		1119 PM	
EVELYN MARIE CREAMER					
3. SEX		4. RACE		5. DATE OF BIRTH	
female		white		MONTH DAY YEAR	
				8 8 13	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md.		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		ANNE ARUNDEL COUNTY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. CLERK	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		A.A.		Glen Burnie	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		219 28 9006	
Presley Joseph Hughes		Elizabeth Marie Miller			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. INFORMANT		ADDRESS	
no		Janet Pate (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8:6 to 8:7-22-85, to 8-6-85, that (I) (we) last saw the deceased alive on 8-6-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
M. D.		MD		8-7-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CHACKIMKAL V. CYRIAC, M. D.		14 WELLHAM AVENUE, SUITE 101			
		GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
cremation		8/9/85		Westview Crematory	
				Catonsville Balto. Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Gonce		AUG 12 1985		Andell	

228057

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E Cronin			2a. DATE OF DEATH MONTH 8 DAY 19 YEAR 85		2b. HOUR M
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 17 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Naval Aca.
13a. STATE Md.		13b. COUNTY A. Arundel	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 181 Woods Drive 21401
14. FATHER'S NAME FIRST Charles MIDDLE Joseph LAST Cronin			15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE LAST Routon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11 412-46-2847		17. INFORMANT ADDRESS Kay Cronin Same as # 13	

18. CAUSE OF DEATH Enter only one cause per line for (1a), (1b) and (1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multi-organ System Failure DUE TO, OR AS A CONSEQUENCE OF Sure for Cardio-vascular disease - 3 yrs DUE TO, OR AS A CONSEQUENCE OF Diabetes, Coronary A. Disease 30 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 7-19-85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardio-vascular A. Disease	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 1 , 19 85 , to August 9 , 19 85 , that (I) (we) last saw the deceased alive on August 9 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE Sally M. Richardson, M.D.	DEGREE M.D.		22c. DATE SIGNED 8/3/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sally M. Richardson, M.D.		22e. ADDRESS 104 Forbes Street Annapolis, Md 21401	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-10-85	23c. NAME OF CEMETERY OR CREMATORY Security Process	23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md.
24. FUNERAL DIRECTOR NAME Cremation Society of Maryland, Balto		25a. DATE REC'D. BY REGISTRAR AUG 13 1985	25b. REGISTRAR'S SIGNATURE Sally M. Richardson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Charles E. Cronin

W. J. Cronin

252030

Items #2a 12/2/85 mth F#610

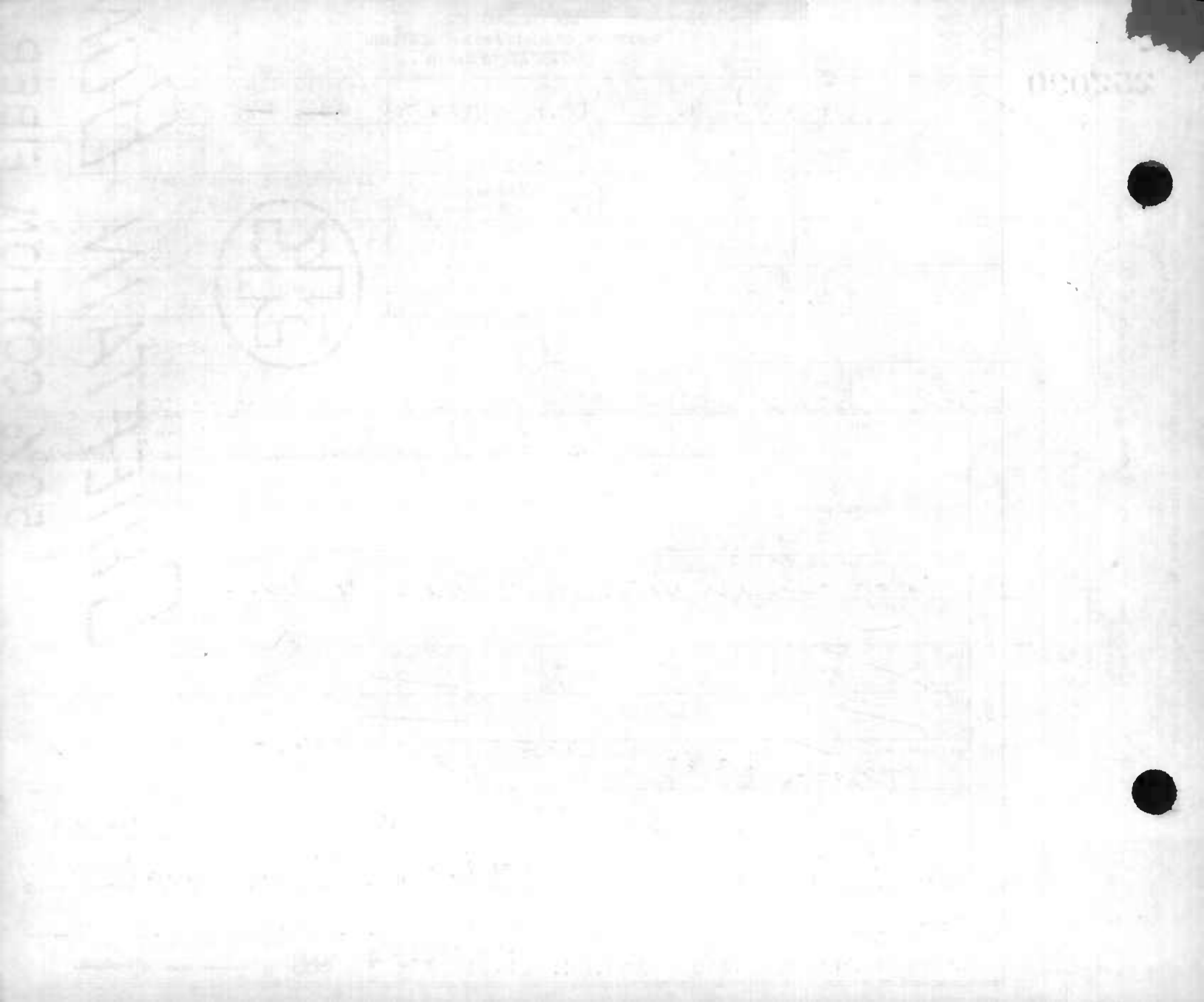
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21330

1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR			
FIRST MIDDLE LAST Herbert W. Cummings			MONTH DAY YEAR September 21, 1985			M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		MONTH DAY YEAR Aug. 15, 1905		80 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Anne Arundel MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel Gen. Hospital				President		Construction	
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		
Md.			A.A. Co.		Edgewater		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Jesse Cummings			FIRST MIDDLE LAST Isabel Asher						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
- NO -			- NO -		214-16-3579 Mary E. Cummings same as 13c				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a colon cancer with metastasis to bone									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 1982, 19, to 9/1/85, 19, that (1) (we) lost saw the deceased alive on 8/30/85, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wm A Cassidy			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm A Cassidy			22e. ADDRESS 171 Defense Hwy, Annapolis 21401						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			9/3/85		Mayo Methodist U.M. Mayo		A.A. Md.		
24 FUNERAL DIRECTOR NAME			ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hardesty Fuenral Home			12 Ridgely Av Ann.Md. 21401		SEP 4 1985		[Signature]		



221032

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annabelle M. Curley			2a. DATE OF DEATH MONTH DAY YEAR 8-1-85			2b. HOUR 33 ⁵ M				
3. SEX FEMALE		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 11-17-1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAP. CONValescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY INSUR. Co.		
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST VICTOR McKay			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Mahlman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 25010955	
17. INFORMANT ADDRESS JACQUELINE DEECK			17. INFORMANT ADDRESS (SAME AS ABOVE #13)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/3/85, 19 to 8/1/85, 19, that (I) (we) lost saw the deceased alive on 8/4, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. D. Goldstein			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/1/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. D. Goldstein			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL			23b. DATE Aug 3, 85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION Glen Burnie, A.A. MD			
24. FUNERAL DIRECTOR NAME BARRANCO F.H.			501 RITCHIE HWY. SEVERNA PK, MD 2146			25. DATE OF INTERMENT AUG 08, 1985		25b. SIGNATURE [Signature]		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the Division of Vital Records, Department of Health and Mental Hygiene, with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10010

Handwritten notes, mostly illegible due to bleed-through. Some visible words include "Females", "Hatched", "Survived", and "Died".

Handwritten notes, mostly illegible due to bleed-through. Some visible words include "Total", "Survived", "Died", and "Hatched".

221068

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCES MAGDALENA DECKER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 02, 1985		2b. HOUR PM 1041
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN. 09, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13e. STREET ADDRESS / ZIP CODE		
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB FISCHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY EIDELE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A		16b. SOCIAL SECURITY NO. 214.48.2074		17. INFORMANT (SISTER) ADDRESS MRS. AMELIA PICHA 800 OAKWOOD RD. GLEN BURNIE, MD. 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-genic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-26 , 19 85 , to 8-2 , 19 85 , that (I) (we) last saw the deceased alive on 8-2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE SANG C. DOH, M.D.		22c. DATE SIGNED 8-3-85			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.		22f. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 6, 1985	23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR AUG 7 1985		25b. REGISTRAR'S SIGNATURE Davidson	

MEDICAL CERTIFICATION

2
9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified at once.

BP



221132

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA Elizabeth DIGGS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 5, 1985		2b. HOUR 605 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6-16-1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY AA	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST David Diggs		15. MOTHER'S MAIDEN NAME FIRST LAST Annie Hall		16. STREET ADDRESS & ZIP CODE 1784 Richfield Dr 21144	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT Myrtle Howard		ADDRESS Severn, Md 21144 1770 Richfield Dr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) bacteremia DUE TO, OR AS A CONSEQUENCE OF (c) Unknown - Death CA Suspected. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sigmoid Obstruction; CVA, CHF, HBP					
19a. DATE OF OPERATION 7/30/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sigmoid Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from 7/13/85 to 8/5/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death.)					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID O. SCHWARTZ, D.O.		22b. ADDRESS 7845 OAKWOOD ROAD #200 GLEN BURNIE, MD. 21061		22c. DATE SIGNED 8/5/85	
23a. BURIAL, CREMATION, REMOVAL Buried		23b. DATE 8-8-1985	23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION Waterbury AA. STATE Md
24. FUNERAL DIRECTOR Wm. Reese & Sons - 821 West St. Annapolis		25. DATE REC'D. BY REGISTRAR AUG 7 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

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SEALING



235141

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21384

1- FOR STATE REGISTRAR Fritz A. Dignen

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRITZ A DIGNEN			2a. DATE OF DEATH MONTH DAY YEAR 8 19 85		2b. HOUR P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 21, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virgin Islands	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4 Ellington Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Civil Service
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4 Ellington Drive 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Hugh A. Dignen, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine L. Heidmann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1WWW 217-05-1267		17. INFORMANT Lorraine Sterling- ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 83 to Aug 19, 19 85, that (I) (we) last saw the deceased alive on June 21, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry R. Nathanson MD		DEGREE MD		22c. DATE SIGNED 8/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON MD		22e. ADDRESS 51 FRANKLIN ST. ANNAP, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest	
23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD		24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD			
25a. DATE REC'D. BY REGISTRAR 100 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21385

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EUGENIA			FIRST DORSEY			LAST			2a. DATE OF DEATH MONTH DAY YEAR 8 14 85			2b. HOUR 11:35 AM		
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR 7 12 1893			6. AGE (IN YEARS LAST BIRTHDAY) 92			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BAY MANOR NURSING HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY A.A.			13c. CITY OR TOWN MILLERSVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P.O. BOX 181 21108		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BELT						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE THOMAS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-26-0732			17. INFORMANT Annapolis, Md. 21401 RACHEL BELT 802 Claiborn Place								
18. CAUSE OF DEATH: Enter only one cause per line, in (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia, Dehydration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>8-2-85</i> to <i>8-14-85</i> , that (I) (we) lost saw the deceased alive on <i>8-13-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE <i>W. Hymae</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8.15.85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C-V. CYRIAC, MD</i>				22e. ADDRESS <i>14 WELHAM AVE. GLENBURNING MD 21061</i>										
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL				23b. DATE 8-17-1985		23c. NAME OF CEMETERY OR CREMATORY MT. TABOR CHURCH CEME.				23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland				
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.				ADDRESS Annapolis, Md. 21401				25a. DATE REC'D. BY REGISTRAR AUG 19 1985						

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KENNETH E. DYSON			2a. DATE OF DEATH MONTH DAY YEAR 29 AUGUST 1985			2b. HOUR A 10:37 M			
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR July 19, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH ET. Meade, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military		12b. KIND OF BUSINESS OR INDUSTRY NATIONAL GUARD	
13a. STATE Connecticut			13b. COUNTY Unknown		13c. CITY OR TOWN Southington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Everett - Dyson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy E. Doucette			16. STREET ADDRESS 40 Edgewood Circle 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Active Duty		17. INFORMANT Joan A. Dyson (Wife)		18. ADDRESS 40 Edgewood Circle Southington, Connecticut		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 42 minutes	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) MYOCARDIAL INFARCTION 2 Hours	
(c) CORONARY ARTERY DISEASE		NOT KNOWN	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

PERIPHERAL VASCULAR DISEASE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1000:29 AUG 29, 1985, to 10:37: AUG 29, 1985, that (I) (we) last saw the deceased alive on 29 AUGUST 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jonathan Safren MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 AUG 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN SAFREN, CPT, MC				22e. ADDRESS KIMBROUGH ARMY COMMUNITY HOSPITAL			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept/3/85		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Southington, Connecticut	
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21381

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SARAH DAYMON ELAM			2a. DATE OF DEATH MONTH DAY YEAR AUG 5 1985		2b. HOUR 4AM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR Dec 29 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md	7b. CITIZEN OF WHAT COUNTRY? U.S.A	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.	
10. CITY OR TOWN OF DEATH HARWOOD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BRASHEARS Private CARE NURSING		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Op	12b. KIND OF BUSINESS OR INDUSTRY Western Elec	
13a. STATE md	13b. COUNTY A.A	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 201 Glenwood 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Howard Daymon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Jeanette Wells			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 312208291		17. INFORMANT ADDRESS ESTHER Hamilton 32 Hicks Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of brain DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of the lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-6 19 84 to 8/5 19 85 , that (I) (we) lost saw the deceased alive on 12-29 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Errol A. Phillip		DEGREE		22c. DATE SIGNED 8/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Errol A. Phillip MD		22e. ADDRESS 1835 Forest Drive ANNAPOLIS, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8-9-1985	23c. NAME OF CEMETERY OR CREMATORY md National mem		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.C. md	
24. FUNERAL DIRECTOR NAME C.B. Hicks		ADDRESS 1922 Forest Drive ANNAPOLIS		25a. DATE REC'D. BY REGISTRAR AUG 7 1985	
				REGISTRAR'S SIGNATURE John Dunder-Rendall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21388

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA A ELLIS			2a. DATE OF DEATH MONTH DAY YEAR 8/9/85			2b. HOUR 4P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1605 Orchard Way				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST George Rudolph		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Granter		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 296-09-1608		17. INFORMANT ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF OVARY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 1983 , 19____, to Aug 9 , 19____, that (I) (we) lost saw the deceased alive on 8/5/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stanley P. Watkins				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.P. WATKINS MD				22e. ADDRESS 51 Franklin St., Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY Pittsburgh Allegheny PA			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				24b. DATE RECEIVED BY REGISTRAR AUG 16 1985					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

220002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ruby Erens			2a. DATE OF DEATH MONTH 8 DAY 4 YEAR 85			2b. HOUR 1:50 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 4 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A. Arundel MD.					
10. CITY OR TOWN OF DEATH Anne Arundel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BAYMANOR Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory worker			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Pasadena				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 50 Luke Drive					
14. FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Potter				15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown				16. ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 128-09-7673		17. INFORMANT Lotus Brumwell ADDRESS 50 Luke Drive Pasadena, Md.							
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Heart										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-3-84 , to 8-4-85 , that (I) (we) lost saw the deceased alive on 8-4-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE E. V. CYRIAC			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-4-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. V. CYRIAC			22e. ADDRESS 101, 14 WELLHAM AVE GLAUBURNIE, MD 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-8-85		23c. NAME OF CEMETERY OR CREMATORY White Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Perinton, Monroe, New York			
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service			ADDRESS Reisterstown, Md.			25a. DATE REC'D. BY REGISTRAR AUG 6 1985			25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

246085

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Sue Eveson			2a. DATE OF DEATH MONTH DAY YEAR August 27, 1985			2b. HOUR P M 2:30 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 405 Joyce Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary, Ret.		12b. KIND OF BUSINESS OR INDUSTRY AAC Bd. of Ed.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 405 Joyce Drive 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Emory C. Warner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Kielholtz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-1952		17. INFORMANT ADDRESS George E. Eveson, Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BREAST CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>4 YRS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>Aug 27</u> , 19 <u>85</u> , to <u>Aug 27</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Aug 27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>GARY I. CORN</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/29/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GARY I. CORN</u>			22e. ADDRESS <u>711 W. 40th ST. BALTO MD. 21211</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 30, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and released, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Permit and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP _____



256003

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEARLY T FLYNN			2a. DATE OF DEATH MONTH DAY YEAR 8-16-85			2b. HOUR 549 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 10 02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A. Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY A. Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 793-A Fairview Ave. 21403	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 110-32-4699		17. INFORMANT ADDRESS 1202 Sterling Dr. Ms. Anna Segelken, Annapolis, Md.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) trip DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE Paul S. Ellis, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8/19/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.					25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

248113

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Virginia Antoinette Fowler</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>August 31, 1985</i>		2b. HOUR <i>9:45 P.m.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8 2 31</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i>	7. UNDER 1 YEAR MONTHS DAYS <i>0 0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD		
10. CITY OR TOWN OF DEATH <i>Millersville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <i>606 Millwright Ct. Apt. 21</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housework</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Anne Arundel</i>	13c. STREET ADDRESS / ZIP CODE <i>606 Millwright Ct. Apt. 21 21108</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Walbert</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virginia E. Skelton</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-26-9980</i>	17. INFORMANT ADDRESS <i>Alfred E. Fowler 606 Millwright Ct. Apt. 21</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary squamous cell carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypoxia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 3</i> , 19 <i>85</i> , to <i>Aug. 31</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Aug. 16</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gregory S. Gordon MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>9-2-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory S. Gordon MD</i>		22e. ADDRESS <i>St. Agnes Hospital 900 Caton Ave.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>9-3-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood, Balto. Co., Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler & Son Inc.</i>		ADDRESS <i>6224 Eastern Ave.</i>		25. DATE REC'D. BY REGISTRAR <i>SEP 3 1985</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Form	File	Index	Folder	Date
Form 100-1	100-1	100-1	100-1	100-1
Form 100-2	100-2	100-2	100-2	100-2
Form 100-3	100-3	100-3	100-3	100-3
Form 100-4	100-4	100-4	100-4	100-4
Form 100-5	100-5	100-5	100-5	100-5
Form 100-6	100-6	100-6	100-6	100-6
Form 100-7	100-7	100-7	100-7	100-7
Form 100-8	100-8	100-8	100-8	100-8
Form 100-9	100-9	100-9	100-9	100-9
Form 100-10	100-10	100-10	100-10	100-10

Form 100-11, 100-12, 100-13, 100-14, 100-15, 100-16, 100-17, 100-18, 100-19, 100-20, 100-21, 100-22, 100-23, 100-24, 100-25, 100-26, 100-27, 100-28, 100-29, 100-30, 100-31, 100-32, 100-33, 100-34, 100-35, 100-36, 100-37, 100-38, 100-39, 100-40, 100-41, 100-42, 100-43, 100-44, 100-45, 100-46, 100-47, 100-48, 100-49, 100-50, 100-51, 100-52, 100-53, 100-54, 100-55, 100-56, 100-57, 100-58, 100-59, 100-60, 100-61, 100-62, 100-63, 100-64, 100-65, 100-66, 100-67, 100-68, 100-69, 100-70, 100-71, 100-72, 100-73, 100-74, 100-75, 100-76, 100-77, 100-78, 100-79, 100-80, 100-81, 100-82, 100-83, 100-84, 100-85, 100-86, 100-87, 100-88, 100-89, 100-90, 100-91, 100-92, 100-93, 100-94, 100-95, 100-96, 100-97, 100-98, 100-99, 100-100.

11/11/11

100% Cotton

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100% Cotton

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

233073

8 5 2 1 3 9 4

1. DECEASED NAME (TYPE OR PRINT) EDWARD H. GEBAUER JR.			2a. DATE OF DEATH MONTH DAY YEAR 8-13-85 2b. HOUR 3:40 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1-25-1910	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO., MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET-AUDITOR 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN LOTHIAN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD HENRY GEBAUER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA SCHABLOSKI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-40-5495	17. INFORMANT ADDRESS HELEN M. GEBAUER (SAME AS #13)		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF b) Sepsis DUE TO, OR AS A CONSEQUENCE OF c) chronic indwelling Foley				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from MAY 1984 to AUG 13, 1985 , that (I) (we) last saw the deceased alive on AUG 13, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE Robert T. Peterson	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-14-1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Peterson	22e. ADDRESS 251 SHAW ST. ANNAPOLIS, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8-16-1985	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PG. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS Co.		ADDRESS 20737 RIVERDALE, Md.	25a. DATE REC'D. BY REGISTRAR AUG 19 1985	25b. REGISTRAR'S SIGNATURE Davidson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner must investigate.

BP

230073

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CHIEF WINTER

242180

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLADU LEONARD GLADU			2a. DATE OF DEATH MONTH DAY YEAR August 17 85			2b. HOUR 6:38 PM			
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 24 15		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) General Hospital Dispat. U.S. Govt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR) U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 718 MT ALBAN DR 21461	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown				16b. SOCIAL SECURITY NO. 579091186		17. INFORMANT 6 DEBORAH CT MD 20659 WAYNE H. GLADU-MECHANESVILLE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 5 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH									
19a. DATE OF OPERATION X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30 PM 8/17 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 709 AM 8/17 85					
22a. I certify that (I) (this hospital) attended the deceased from 3:30 PM 8/17 85 to 7:09 AM 8/17 85 , that (I) (we) last saw the deceased live on 8/17 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE OF PHYSICIAN Henry H. Canton				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry H. CANTON				22e. ADDRESS 51 FRANKLIN ST #40 ANNAPOLIS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/22/85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS AA MD			
24. FUNERAL DIRECTOR John S. Barancko ADDRESS Severna Park				25a. DATE REC'D. BY REGISTRAR 2.6 1985		25b. REGISTRAR'S SIGNATURE John S. Barancko			

MEDICAL CERTIFICATION

BP. _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers, place in envelope, and return to the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

213120

23317 MOTION NO. 2

10/1/14

11/1/14

12/1/14

1/1/15



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238013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21396

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			ESTIMATED MONTH DAY YEAR			2b. HOUR			
MATTIE			B.			GLENN			<input checked="" type="checkbox"/> 8 16 1985			4:53 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		Black		6 2 1944		41 YRS.						8 16 1985		4:53 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
South Carolina				U. S. A.								Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie				North Arundel Hospital				Weaver				Textile			
13a. STATE				13b. CITY OR TOWN				13c. CITY LIMITS?				13d. STREET ADDRESS			
Pennsylvania				Philadelphia Philadelphia				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				6607 Blakemore Street 9919119			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Richard H. Brown, Sr.				Beatrice Maffett											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				249-86-2260				James Brown				6607 Blakemore St. Phil., Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Ann M. Dixon, M.D.				M.D. Assistant				8-17-85							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Ann M. Dixon, M.D.				111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				8-22-85		Cem. Flint Hill Baptist Church				CITY OR TOWN COUNTY STATE					
										Newberry, South Carolina					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Marzullo Funeral Service				Reisterstown, Md.				AUG 22 1985				John Davidson-Rodgers			

DIVISION OF VITAL RECORDS, 401 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH-17
(VR A15 ME (5))

• *Journal of Management Education* 25(10):1139-1150

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21397	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR
BENJAMIN JOSEPH GORDON									AUG-23-85		19
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
MALE	WHITE	OCT. 11, 1970		14	YRS.				AUG -23-85		5:46P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
OHIO			U.S.A.						ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie			North Arundel Hospital						STUDENT		HIGH SCHOOL
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		A.A.		LINTHICUM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		418 FOREST VIEW RD. 21090			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
RICHARD W. GORDON				CHERYL D. DAVIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT (MOTHER) ADDRESS			
NO				N/A				215.02.2198 MS. CHERYL D. DAVIS SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY: 8126 IMMEDIATE CAUSE (a) Multiple injuries											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				4:21PM 8-23-85		bicyclist in collision with an auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
				street		Fort View Rd. Linthicum., Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korell, M.D.				Assistant				8-24-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				AUG. 27, 1985		GLEN HAVEN MEM. PARK		GLEN BURNIE A.A. MD.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061						AUG 27 1985		John Davidson-Randall			

BP
DHMH - 17
(VR A15 ME (5))

2101AS

100-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

238007

1. DECEASED NAME (TYPE OR PRINT) <i>Nellie A. Guyette</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 9 85</i>			2b. HOUR <i>10p</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 11 10</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>WA USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Senior Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md</i>				13c. CITY OR TOWN <i>Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1130 University Blvd W 20903</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Rubin Edwin Nichols</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Effie Vaughn</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>5P7-05-2284</i>		17. INFORMANT ADDRESS <i>William C Guyette Same as #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>mesmeric interaction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION <i>8/9/85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mesmeric interaction</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>8/9 85 to 8/9 85</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/9 85</i> , 19 <i>85</i> , to <i>8/9 85</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>8/9 85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John L. Nichols</i>				DEGREE <i>M.D.</i>				22c. DATE SIGNED <i>8/9/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MAHATMA, John L., MD</i>				22e. ADDRESS <i>1703 Giddings Avenue, Annapolis</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>14Aug1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland PG MD</i>			
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>				ADDRESS <i>Suitland, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 19 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rendall</i>	

MEO Dr. Jones Notified and released

MEDICAL CERTIFICATION

2112

246117

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie HAEFNER			2a. DATE OF DEATH MONTH DAY YEAR August 16 85			2b. HOUR 8:59A M					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 15 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Crownsville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE Fairfield Loop Road 21032											
14. FATHER'S NAME FIRST MIDDLE LAST Edward Manning					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Bagalika						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Richard E. Haefner - Annapolis, MD 21401						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Inanition DUE TO, OR AS A CONSEQUENCE OF (c) Advanced age								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Spontaneous pathologic pelvic fracture											
19a. DATE OF OPERATION Sept 28 85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from Sept. 28 , 19 81 , to Aug. 16 , 19 85 , that (I) (we) st viewed the deceased alive on Aug. 15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE Charles W. Kinzer			DEGREE M.D.			22c. DATE SIGNED 8/16/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, M.D.			22e. ADDRESS 16 Murray Avenue, Annapolis, MD 21401								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/31/85			23c. NAME OF CEMETERY OR CREMATORY Hollywood Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Union Union NJ		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD			25a. DATE REC'D. BY REGISTRAR AUG 28 1985							25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be contacted at once.

226058

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) LEONA BEAN HALE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 7, 1985		2b. HOUR 7:33 A.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR NOV. 26, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VERMONT	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY HEALTH CARE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE FLORIDA			13b. CITY OR TOWN DADE	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 5867 DEVONSHIRE BLVD. 33155
14. FATHER'S NAME FIRST MIDDLE LAST BEAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MURIEL HOWE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT T. Geoffrey Hale Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line, and (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Septicemic Shock Duke Myocardial Infarction Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs 1-2 hrs Year					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8-5-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE HILARY T. O'HERLIHY, M.D.		DEGREE M.D.		22c. DATE SIGNED 8-7-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/7/85	23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto., MD
24. FUNERAL DIRECTOR NAME 299 Frederick Road Balto., Md. 21228			25. DATE REC'D. BY REGISTRAR AUG 9 1985		
26. REGISTRAR'S SIGNATURE Gordon Randell					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16-30M 4/83
(VRA 15, 4)

171155



219071

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21401

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William L. Hall			2a. DATE OF DEATH MONTH DAY YEAR 8 3 85			2b. HOUR 9:30P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 15 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 303 West Arundel Road (Home)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Asphalt	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Hall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Saunders						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 218-07-0075		17. INFORMANT Gladys E. Hall		ADDRESS Same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Ca of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-21 , 19 85 , to 8-4 , 19 85 , that (I) (we) lost saw the deceased alive on 6-27 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.									
22b. SIGNATURE Paul E. Gormley			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/5/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. GORMLEY, M.D.			22e. ADDRESS 900 Caton Ave. Baltimore, Md. 21229						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Entombment			23b. DATE 8/7/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md		
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hgwy Balto Md					25a. DATE REC'D. BY REGISTRAR AUG 5 1985		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

240073

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21402

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR					
JAMES			T.			HART			xx8-20-85			19					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		White		White June 17 78		YRS.						8-25-85		12:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Pennsylvania			USA			1907			Anne Arundel County MD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Odenton			8318 Telegraph Road						machine operator			plastics plan					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13b. CITY OR TOWN		13c. STREET ADDRESS			
Maryland												Anne Arundel		Odenton		8318 Telegraph Road 21113	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William J. Hart						Mary Josephine Slane											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
no				211 09 5916				Louise Zomp, 238 Bentbough Dr Leesburg Fla									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				M.D. Assistant				DATE SIGNED				8-25-85					
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				Aug. 26, 1985				Emmanuel Cemetery				Scaggsville, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Donaldson Funeral Home, Laurel, Maryland								AUG 26 1985		[Signature]							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 FOR BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

EX00013

13814 MOTION 1/20/21

218035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANKYLATION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND - 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

218035

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR			
Scott Miller HATTON				7 30 1985				1730			
3. SEX	4. RACE	5. DATE OF BIRTH	6. YEARS	7. UNDER 1 YR.	8. UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD				7d. HOUR	
Male	White	Nov. 28 1962	22			7 30 1985				1820	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Michigan		U.S.A.				Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		North Arundel Hospital				Machinist		Atlantic Pro			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
Maryland	Anne Arundel	Severna Park	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	478 St. Brides Court 21146							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
William E. Hatton				Carolyn Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				381-64-6747		James Hourihane 478 St. Brides Ct. 21146					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
8192 IMMEDIATE CAUSE (a) <u>Cranial trauma (massive) + chest trauma</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <u>Motorcycle accident</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
James E. Wheeler, M.D.				M.D. 1476 Gumbottom Road				7-30-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
James E. Wheeler, M.D.				Crownsville 21032							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				Aug. 3, 1985		Garfield Cemetery		Linwood, Bay County Michigan			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS				AUG 2 1985				Julia Davidson-Rondeau			
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue											

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21404

1. DECEASED NAME (TYPE OR PRINT) ELOISE			2a. DATE OF DEATH MONTH DAY YEAR Aug 27 85			2b. HOUR 3:15 P.M.					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct 17 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH SEVERNA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 SEVERN AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MD.			13b. CITY OR TOWN A.A. SEVERNA PARK			13c. STREET ADDRESS / ZIP CODE 105 SEVERN AVE 21146			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT LEE BAKER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA M. MILLNER			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -				17. SOCIAL SECURITY NO. 215 50 3250	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Nasopharyngeal carcinoma 8 years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/11/85, 1985, to 8/27, 1985, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stuart E. Selovick			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selovick			22e. ADDRESS 51 Franklin St. Annapolis, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 8/28/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE P.G. MD.				
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel			ADDRESS Annapolis, Md.			25a. DATE RECEIVED BY REGISTRAR AUG 28 1985		25b. REGISTRAR'S SIGNATURE J. Anderson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some faint words and symbols are visible, including what appears to be a large 'X' or 'Z' in the upper left, and various numbers and letters scattered throughout the text.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

234032

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marie A. Hepting			2a. DATE OF DEATH MONTH DAY YEAR 8 14 85			2b. HOUR 5:00A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 6 14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 136 Wileys Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home Maker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Otto Strippy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Frank			13e. STREET ADDRESS / ZIP CODE 8200 Fort Smallwood Road 21226			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-01-4034		17. INFORMANT ADDRESS Robert M. Hepting 21122			175 Teal Dr. Pasadena Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Lungs DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Pancreas, body DUE TO, OR AS A CONSEQUENCE OF (c) Shortly after death APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months 12 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Shortly after death									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (the hospital) attended the deceased from 8-21 , 19 67 , to 8-14 , 19 85 , that (1) (the) last saw the deceased alive on 8-9 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) did not view the body after death.									
22b. SIGNATURE Benjamin Berdanna				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN BERDANNA				22e. ADDRESS 606 Hammond Lane					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/17/85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md			
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR AUG 15 1985		25b. REGISTRAR'S SIGNATURE John Davidson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANOR MARIE HORNING			2a DATE OF DEATH MONTH DAY YEAR AUGUST 10, 1985		2b HOUR 145 PM						
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7 UNDER 1 YEAR MONTHS DAYS 87		8 UNDER 24 HRS HOURS MIN. 87	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10 CITY OR TOWN OF DEATH GLEN BURNIE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home			
13a STATE MD		13b COUNTY Anne Arundel		13c CITY OR TOWN Severna Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 471 Fair Oaks Dr. 21146			
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Smith				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Stitt							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-48-8295		17 INFORMANT ADDRESS Marjorie H. Byrne 4619 - 48th St. NW							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/9 8 19 85		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 7445A TURNBULL FRANCH ROAD GLEN BURNIE, MARYLAND 21061							
22a I certify that (I) (this hospital) attended the deceased from 8/9 19 85 , to 8/10 19 85 , that (I) (we) last saw the deceased alive on 8/10 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
22b SIGNATURE John F. Kressler, M.D.		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/10/85			
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN F. KRESSLER, M.D.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/15/85		23c NAME OF CEMETERY OR CREMATORY Arlington, Nat'l. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Arlington, VA					
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash, DC 20016						25a DATE REC'D. BY REGISTRAR AUG 15 1985		25b REGISTRAR'S SIGNATURE Gelia Davidson-Randall			

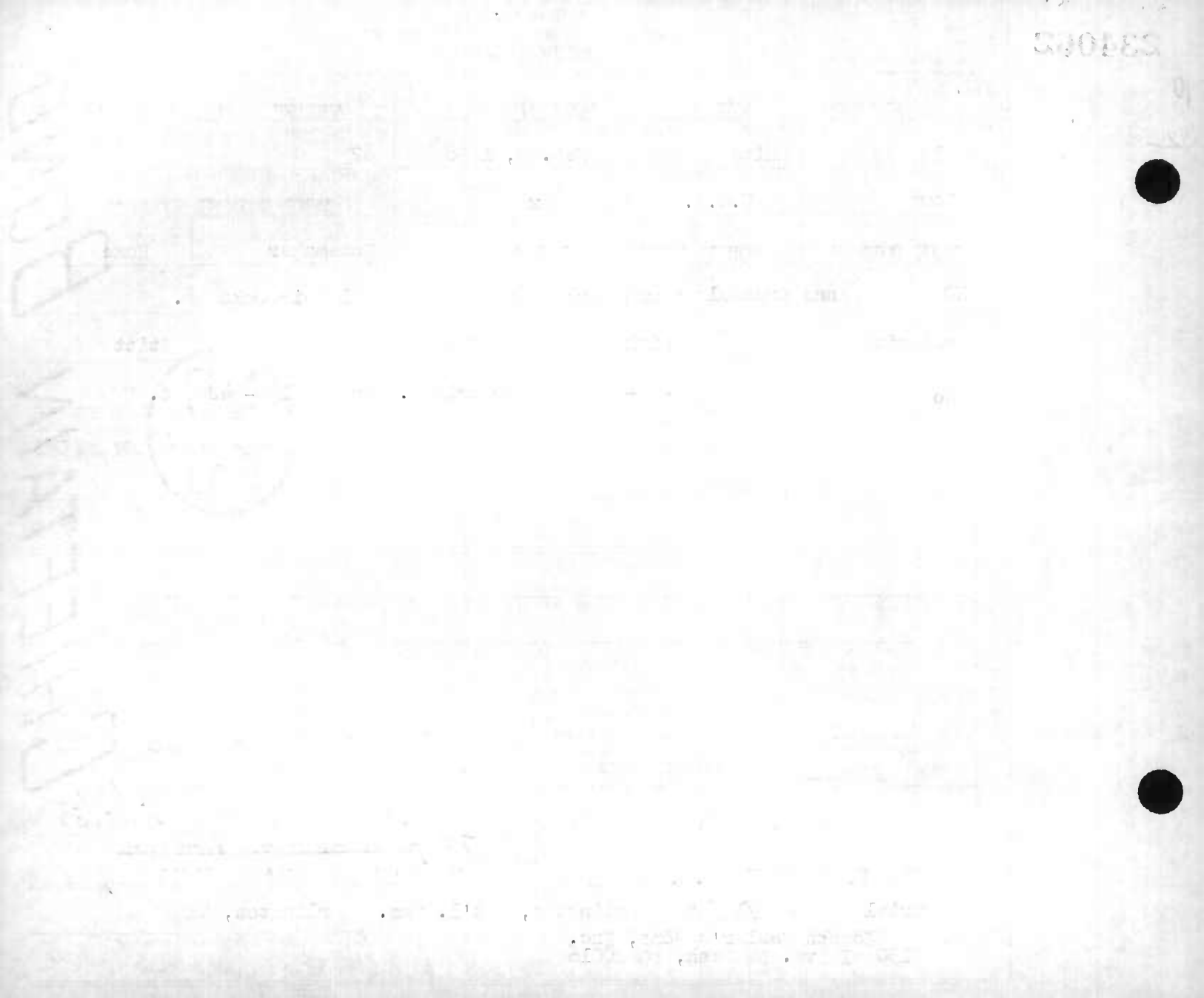
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



221010

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR									
BETTY						HOWARD		Y 4 19 85		Y 4 19 85		Y 4 19 85		Y 4 19 85		1345-1520									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR					
Female		White		3 17 23		62 YRS.						Y 4 19 85		Y 4 19 85		Y 4 19 85		Y 4 19 85		220					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH													
Virginia				U.S.								Anne Arundel County MD.													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Glen Burni				N. Arundel Hosp.								Homemaker													
13a. STATE																13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		13e. STREET ADDRESS		13f. STREET ADDRESS	
Md.																Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		457 Mary Kay Court		21090			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
FIRST				MIDDLE				LAST				FIRST				MIDDLE				LAST					
												Virgil				Barthalamo									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				(YES, NO, OR UNKNOWN)				(IF YES, GIVE WAR OR DATES)				219-20-5449				Mr. Larry Howard				Same as #13					
Unkn.																									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a)																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																									
(b)																									
DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?									
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
				HOUR A.M. MONTH DAY YEAR																					
				P.M. 19																					
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION																	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																									
TITLE (SPECIFY)																									
ACTUAL SIGNATURE				MEDICAL EXAMINER												DATE SIGNED									
James E. Wheeler, M.D.				1776 Gumbottom Road												8-4-85									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																					
James E. Wheeler, M.D.				Crownsville 21032																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY STATE									
Removal				8/5/85								CITY OR TOWN													
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE									
NAME				ADDRESS																					
Anatomy Board				Balto., Md.												AUG 07 1985									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF THE WORD "DECEASED". IN THE CASE OF A FETUS, THE CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 7 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 8 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 9 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 10 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201.

BP

 DHMH - 17
 (VR A15 ME (1))
 20M 4/82

Handwritten notes at the top of the page, including the word "BETTER" and other illegible scribbles.

Main body of handwritten notes, appearing as a list or series of entries, mostly illegible due to fading.

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220045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21408

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH M HOWDERSHELL			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 2, 1985		2b. HOUR 2:35 PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 21, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH ARNOLD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A PLACE, GIVE STREET ADDRESS) 1246 TAMARACK TRAIL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INS. UNDERWRITER		12b. KIND OF BUSINESS OR INDUSTRY ATWELL CO.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE N/A			13b. COUNTY N/A		13c. CITY OR TOWN WASHINGTON, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE A. SPALL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE P. McANDREW					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-10-8279		17. INFORMANT ADDRESS ELLEN T. COLLINS SAME AS 11 DAUGHTER				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>recurrent lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>9 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 84</u> to <u>Aug 2</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>July 27</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two did not view the body after death.								
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Aug 5, 1985</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER PUSHKAS				22e. ADDRESS 11510 OLD GEORGETOWN RD., ROCKVILLE, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/6/85		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, PRI GEO., MARYLAND		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR AUG 6 1985				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21409

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANK A. HOWELL			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 1, 1985		2b. HOUR 1:40 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MARCH 12, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DURYEA, PENN.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH CROWNSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) APT. B-12		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE HOSPITAL		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN CROWNSVILLE	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST WILBUR HOWELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA KIERAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 725-09-5355	17. INFORMANT ADDRESS PATRICIA POOR WOODSTOCK, GEORGIA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cancer pancreas + liver. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year - months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hyper-tension and coronary artery disease.					
19a. DATE OF OPERATION Sept 82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hyper-tension and coronary artery disease.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 82 to Aug 85 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the day and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE William H. Choate, MD.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. CHOATE, MD		22e. ADDRESS 2083 WEST STREET ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-5-85	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS		23d. LOCATION CITY OR TOWN COUNTY STATE LAZERNE CO. PITTSBURGH, PENN.
24. FUNERAL DIRECTOR NAME ADDRESS BEALL-EVANS FUNERAL HOME ANNAPOLIS, MD.		25. DATE REC'D. BY REGISTRAR (TYPE OR PRINT) AUG 9, 1985 <i>John Davidson-Randall</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21410

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MACK H. HUMPHRIES, SR.			2a. DATE OF DEATH MONTH AUGUST DAY 16 YEAR 1985			2b. HOUR 12³⁰ P.M.	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH 6 DAY 10 YEAR 24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 102 N. CRAIN HWY., APT 958				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER SALESMAN	
12b. KIND OF BUSINESS OR INDUSTRY BEER		13a. STATE MD					
13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 102 N. Crain Hwy., Apt 958 21061	
14. FATHER'S NAME FIRST Quinten MIDDLE M. LAST Humphries		15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE B. LAST Robinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> WWII			
16b. SOCIAL SECURITY NO. 214 180116		17. INFORMANT Mary L. Humphries, 102 N. Crain Hwy Apt 958					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic Obstructive lung disease							
19a. DATE OF OPERATION Aug 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of cancer of lung		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 11 , 19 68 , to Aug 16 , 19 85 , that (I) (we) last saw the deceased alive on July 30 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J.C. Cullen, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. Cullen, M.D.				22e. ADDRESS 7 RIGGS AVENUE, SEVERNA PARK, MD 21144			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Aug. 20, 1985		23c. NAME OF CEMETERY OR CREMATORY MD. Vets (Crownsville)		23d. LOCATION CITY OR TOWN Crownsville COUNTY A.A. STATE MD	
24. FUNERAL DIRECTOR NAME McCully Funeral Home		ADDRESS 3376 Patuxent Ave Balt. MD 21225		25a. DATE REC'D. BY REGISTRAR AUG 19 1985			

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21411
20 DATE OF DEATH MONTH DAY YEAR 8-18-85 26 HOUR 11:25 AM

1. DECEASED NAME FIRST MIDDLE LAST PAUL HURBAN JR

3 SEX MALE 4 RACE White 5. DATE OF BIRTH MONTH DAY YEAR Aug 9, 1921 6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.

10 CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Court Reporter 12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY AA 13c CITY OR TOWN Annapolis 13d INSIDE CITY LIMITS? YES ☐ NO ☒ 13e STREET ADDRESS / ZIP CODE 125 Island View Drive 21401

14 FATHER'S NAME FIRST MIDDLE LAST Paul Hurban, Sr. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hurley

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES 16b SOCIAL SECURITY NO. 202-03-8280 17 INFORMANT ADDRESS Charlotte L. Hurban - Same as #13

18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic Biliary TRACT Cancer

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Jan '85 ->

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED 9-20-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS 51 FRANKLIN ST Annapolis MD 21401

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug 21, 1985 23c. NAME OF CEMETERY OR CREMATORY Hillcrest 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Taylor Funeral Chapel - Annapolis, MD

AUG 21 1985

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



242135

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDC

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ETHELYN E. JACKSON			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 22, 1985		2b. HOUR 458 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10 15 03	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Millersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Baldrige			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Vincent		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 554-30-0265		16c. ADDRESS Harvey Jackson 8280 Brookwood Road 21108	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> UTI DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD ECHF AS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>old CVA & SOB</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>84</u> , to <u>8 22</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8 21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mustafa C. Oz, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 8 22 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUSTAFA C. OZ, M.D.		22e. ADDRESS 605 BALTIMORE-ANNAPOLIS BLVD SEVERNA PARK, MARYLAND 21146			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-26-85	23c. NAME OF CEMETERY OR CREMATORY Rose Hills MEM. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Whittier California	23e. ZIP CODE 90601	
24. FUNERAL DIRECTOR NAME Raymond C. Fink		ADDRESS Glen Burnie, Md. 21061		25. DATE REG. BY REGISTRAR AUG 22 1985	

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Received at the office of the

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21413

1. DECEASED NAME (TYPE OR PRINT) Mildred Jones Jackson			2b. DATE OF DEATH MONTH DAY YEAR Aug. 18, 1985			2a. HOUR 11:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 26, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 10 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1877 Luce Creek Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude G. Miller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-30-8541	
17. INFORMANT Same as		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4</u> , 19 <u>77</u> , to <u>8</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>10</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Enser W. Cole</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Enser W. Cole				22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS MD 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 21, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				25a. DATE REC'D. BY REGISTRAR Aug 21 1985			
25b. REGISTRAR'S SIGNATURE <u>Enser W. Cole</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the Medical Examiner must be notified.)

BP _____

224045

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21414

1. DECEASED NAME (TYPE OR PRINT) PHILLIP P Johnson			2a. DATE OF DEATH MONTH DAY YEAR 8-7-85		2b. HOUR 0925 AM	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 11 28 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE MD		13b. CITY OR TOWN ANNAPOLIS		13c. STREET ADDRESS / ZIP CODE 24 Lincoln Heights 21401		
14. FATHER'S NAME FIRST MIDDLE LAST JOHNNY JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE BROWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 212-18-5160		17. INFORMANT ADDRESS Annapolis, Md. 21401 ALMA W. JOHNSON 24 Lincoln Heights		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic colonic CA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) _____						
MEDICAL CERTIFICATION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from November 19, 83, to August 7, 1985, that (I) (we) last saw the deceased alive on August 7, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stuart E. Selonick, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/7/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.		22e. ADDRESS 51 Franklin Street Annapolis, Md. 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-10-1985		23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Md. A.A. Maryland		25a. DATE REC'D. BY REGISTRAR AUG 8 1985		

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STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

242165

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH		MONTH	DAY	YEAR	20. HOUR	
JOHN WALTER				JONES. JR	August 26 85					P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		DEC 18 1920		64		MONTHS		DAYS	
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		70. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12. KIND OF BUSINESS OR INDUSTRY					
Hannapolis		ARGEN Hospt.		REAL ESTATE INVESTMENT							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		ZIP CODE	
MD.		AA		Hannapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1 HORN Pt. Court		21403	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
JOHN WALTER JONES JR		REGINA McNAULY		YES		219 03 5609		FRANCES G. JONES		# 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)										Hypervcalcemia	
DUE TO, OR AS A CONSEQUENCE OF										1 month	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Renal cell carcinoma	
(b)										2 months	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from July 15, 1985, to 8/26, 1985, that (I) (we) lost saw the deceased alive on 8/26, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Stuart E. Selovich, M.D.				M.D.				8/28/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Stuart E. Selovich, M.D.				51 Franklin St. Annapolis							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE	
Burial		8/30/85		GLEN HAVEN		GLENVIEW		AA		MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
TAYLOR FUNERAL CHAPEL		AUG 28 1985		John Davidson-Randall							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DATE

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block]

[Illegible text block]

226025

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA ADELE JORDON			2a. DATE OF DEATH MONTH DAY YEAR 8-2-85			2b. HOUR MIN. 0145 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2-25-04		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS ANNE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ARUNDEL GENERAL HOSPITAL LICENSED PRATICAL NURSE				12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) HOSPITAL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY ANNAPOLIS		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD THOMAS ROBBINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCIA GEEKIE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-30-4888		17. INFORMANT ADDRESS NORMA J. GREEN R.D. 3 BOX 82 PINE GROVE, PENN. 17063					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIORESPIRATORY ARRESTBIOLOGICAL INTERVAL
BETWEEN ONSET AND DEATH**5 MINUTES**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **CARCINOMA OF UNKNOWN PRIMARY, WITH**

DUE TO, OR AS A CONSEQUENCE OF

METASTASIS TO BRAIN**6 MONTHS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 7/22 19 85 , to 8/2 19 85 , that (b) (we) lost saw the deceased alive on 8/1 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Scott Eden, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT SCOTT EDEN, M.D.				22e. ADDRESS 703 GIDDINGS AVE. ANNAPOLIS MD 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-5-85		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS ANNE ARUNDEL MARYLAND	
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS ANNAPOLIS, MARYLAND				25. DATE REC'D. BY REGISTRAR AUG 12 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," show any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten notes and markings on the left margin, including the letters 'M', 'N', 'I', and 'C'.

Handwritten text at the top of the page, possibly a title or header.

Main body of handwritten text, appearing to be a list or series of entries, though the handwriting is very faint and difficult to decipher.

238118

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) EDWIN C KELLOGG SR			2a. DATE OF DEATH MONTH AUGUST DAY 14 YEAR 1985			2b. HOUR 300 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 27 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Officer		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Walter MIDDLE E. LAST Kellogg		15. MOTHER'S MAIDEN NAME FIRST Rebecca MIDDLE H. LAST Beans		13e. STREET ADDRESS / ZIP CODE 4 N. Broadview Blvd. 21061			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 161-09-0280		17. INFORMANT Evelyn Morrison same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unfavorable factors DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Ch of prostate Or of colon DUE TO, OR AS A CONSEQUENCE OF (c) with metastasis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14-24	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/10 19 85 to 8/14 19 85 , that (I) (we) last saw the deceased alive on 8/13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type or Print) SERGIO V. ALVAREZ		22e. ADDRESS 300 HOSPITAL DR., SUITE 134 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 15 Aug. 85		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley ADDRESS Glen Burnie MD 21061				25a. DATE REC'D. BY REGISTRAR AUG 16 1985 25b. REGISTRAR'S SIGNATURE [Signature]			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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233072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDWARD HOLMES KEPPER			2a. DATE OF DEATH MONTH AUGUST DAY 10 , YEAR 1985		2b. HOUR 430 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH MARCH DAY 23 , YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BURNING FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRICKLAYER	12b. KIND OF BUSINESS OR INDUSTRY MASONERY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN ARNOLD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1442 MIDDLEWAY 21012	
14. FATHER'S NAME FIRST CHARLES MIDDLE KEPPER LAST KEPPER			15. MOTHER'S MAIDEN NAME FIRST AMELIA MIDDLE FESSMAN LAST FESSMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 262-05-7150	17. INFORMANT ADDRESS HILDAGARDE M. KEPPEP SAME AS 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio resp. arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Anoxic encephalopathy, Diabetic					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/11/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHADELWAL, M.D.		22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BOULEVAR GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL CREMATION	23b. DATE 8-12-85	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN ALEXANDRIA FAIRFAX CO. VIRGINIA	23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR ROBERT E. EVANS ANNAPOLIS, MARYLAND		25a. DATE REC'D. BY REGISTRAR AUG 16 1985	25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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REPORT

NO. 1

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233024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) NAOMI Kirby										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN	
3. SEX F	4. RACE Neg	5. DATE OF BIRTH MONTH 4 DAY 13 YEAR 25	6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	2c. DATE PRONOUNCED DEAD 8 10 19 85		2d. HOUR 1440			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1130 A Madison Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1152 Eastport Terrace			
14. FATHER'S NAME FIRST CLARENCE MIDDLE STAANTON LAST JOHNSON				15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE JOHNSON LAST JOHNSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-28-6998		17. INFORMANT 1152 Eastport Terrace LANDERS R. KIRBY Annapolis, Md. 21403					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. A.S.C.V.D. (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE William P. Jones, M.D.						TITLE (SPECIFY) DEPUTY		MEDICAL EXAMINER		DATE SIGNED 8/10/85	
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.						ADDRESS 695 America Crt., Davidsonville, Md. 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8-14-1985		23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY				23d. LOCATION CITY OR TOWN Annapolis COUNTY A.A. STATE Maryland	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. ADDRESS Annapolis, Md. 21401						25a. DATE REC'D. BY REGISTRAR (DATE) AUG 19 1985 REGISTRAR'S SIGNATURE J. Davidson-Randall					

BP _____

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
FIRST MIDDLE LAST Craig Morgan Kirkendall			MONTH DAY YEAR 8/18/85			C:00P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	MONTH DAY YEAR 9 5 39	45			MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
New York	USA		Anne Arundel Co. MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR	
Annapolis	Anne Arundel General Hospital			Sales Engineer			Packaging Products	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b COUNTY	13c CITY OR TOWN	13d STREET ADDRESS / ZIP CODE					
MD	AA	Annapolis	1138 Hampton Road 21401					
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Stanley Kirkendall			Jane Morgan					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
Yes			084-30-6552			Shirley M. Kirkendall. Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Squamous Carcinoma with metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mos.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> 19 <u>85</u> to <u>Aug 17</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>Aug 17</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above. (I) (we) (did) (did not) view the body after death.			22b SIGNATURE (Signature)			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/18/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS 51 Franklin Street, Annapolis, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Cremation			Aug 19, 1985		Cedar Hill		Suitland P.G. MD	
24 FUNERAL DIRECTOR NAME ADDRESS						25a DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Taylor Funeral Chapel - Annapolis, MD						AUG 21 1985 [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8

New York
The following is a list of the names of the persons who have been
admitted to the office of the Secretary of the State of New York
since the 1st of January, 1901, and who have been sworn in as
members of the State Bar of New York.

1. *[Faint, illegible text]*
2. *[Faint, illegible text]*
3. *[Faint, illegible text]*
4. *[Faint, illegible text]*
5. *[Faint, illegible text]*
6. *[Faint, illegible text]*
7. *[Faint, illegible text]*
8. *[Faint, illegible text]*
9. *[Faint, illegible text]*
10. *[Faint, illegible text]*

11. *[Faint, illegible text]*
12. *[Faint, illegible text]*
13. *[Faint, illegible text]*
14. *[Faint, illegible text]*
15. *[Faint, illegible text]*
16. *[Faint, illegible text]*
17. *[Faint, illegible text]*
18. *[Faint, illegible text]*
19. *[Faint, illegible text]*
20. *[Faint, illegible text]*

232124

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20. DATE OF DEATH MONTH DAY YEAR 2b HOUR
8 14 85 1:30 A.M.

1. DECEASED NAME (TYPE OR PRINT) STELLA KLIPSTEIN		20. DATE OF DEATH MONTH DAY YEAR 2b HOUR 8 14 85 1:30 A.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MAR 17 1903	6. AGE (IN YEARS LAST BIRTHDAY) 82 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ADARUNDEL MD.
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY NASSAU CO NY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD.	13b. COUNTY AA	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL HUMIERE	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN	13e. STREET ADDRESS / ZIP CODE 1105 T.C. LAKE HERON DR 21403	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 111 01 3821	17. INFORMANT ADDRESS BOB KLIPSTEIN #13	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTESTINAL Pseudo-OBSTRUCTIONAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) HYPOTHYROIDISM

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

DEBILITATING ARTHRITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 8/13 19 85, to 8/14 19 85, that (I) (we) last saw the deceased alive on 8/13 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE A J CALABRESE	DEGREE	22c. DATE SIGNED 8/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A J CALABRESE	22e. ADDRESS DEFENSE HWY ANNAP. MD 21401		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/16/85	23c. NAME OF CEMETERY OR CREMATORY HILLCREST	23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS AA MD.
24. FUNERAL DIRECTOR NAME ADDRESS TAYLOR FUNERAL CHAPEL ANNAPOLIS MD	25a. DATE REC'D. BY REGISTRAR AUG 16 1985		
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN F. KLOMAN			2a. DATE OF DEATH MONTH 8 DAY 21 YEAR 1985			2b. HOUR 3:25 P.M.					
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH 5 DAY 20 YEAR 1904		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		7b. IF UNDER 72 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Crawnsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Secretary		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Anne Arundel 13d. CITY OR TOWN Annapolis				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 701 Glenwood St 21401					
14. FATHER'S NAME FIRST Joseph MIDDLE LAST Facer				15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Jerowski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-05-2986		17. INFORMANT 416 Fernwood Court Lucille Young Severna Park MD 21146					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) dementia - febrile illness.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4-19-84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Present					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1833 Forest Drive Annapolis, Md					
22a. I certify that (I) (the hospital) attended the deceased from 8-17-85 to 8-22-85 that (I) (we) last saw the deceased alive on 8-17-85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Peter F. Verkoewen			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/22/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOEVEN			22e. ADDRESS 1833 FOREST DRIVE ANNAPOLIS, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-22-85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Anne Arundel MD			
24. FUNERAL DIRECTOR NAME Robert Barranco			ADDRESS 495 Ritchie Hwy Severna Park MD 21146			25. DATE REC'D. BY REGISTRAR Aug 26 1985			25b. REGISTRAR'S SIGNATURE Jane Gordon-Randall		



RECEIVED
MAY 11 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

227072

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. GIVE PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21423
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lelia Korczynski			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 19 YEAR 1985			2b. HOUR M 13		
3. SEX Female	4. RACE CAU	5. DATE OF BIRTH MONTH 7 DAY 28 YEAR 1973	6. AGE (IN YEARS) LAST BIRTHDAY 73	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH 8 DAY 11 YEAR 1985	7d. HOUR M 13	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7739 Overhill Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MD			13b. CITY AA		
13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7739 Overhill Rd		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Fleming				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-26-3528		17. INFORMANT ADDRESS 202 Sunset Dr. Joseph F. Korczynski, Glen Burnie 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) A.S.C. V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Q.V.D.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones			TITLE (SPECIFY) M.D. DEPUTY			MEDICAL EXAMINER		DATE SIGNED 8/11/85
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Ct., Davidsonville, Md. 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 14 Aug. 85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD		
24. FUNERAL DIRECTOR NAME James S. Kirkley				ADDRESS Glen Burnie, MD 21061		25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall

1. 1/2 lb. of ...
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BP

DHMH - 16 60M 7/B4
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

FOR 1. STATE REGISTRAR		256022	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST ERVIN CARL LANG		MONTH DAY YEAR AUGUST 9, 1985	
3. SEX Male		2b. HOUR 7:44 A M	
4. RACE Caucasian		6. AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH MONTH DAY YEAR 4 - 26 - 25		60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? United States	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BANKER		12b. KIND OF BUSINESS OR INDUSTRY MARYLAND National	
13a. STATE Maryland		13b. COUNTY Anne Arundel	
13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Lang		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 299-18-5752	
17. INFORMANT ADDRESS Esther Lang. (Same as #13)			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION 8/5/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured diverticulum	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>8/5</u> 19 <u>85</u> , to <u>8/9</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) have (do not) view the body after death.			
22b. SIGNATURE <u>John F. Kressler, M.D.</u>		22c. DATE SIGNED 8/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN F. KRESSLER, M.D.		22e. ADDRESS 200 HOSPITAL DRIVE, #510 GLEN BURNIE, MARYLAND 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-12-85	
23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Anne Arundel MD	
24. FUNERAL DIRECTOR NAME Robert Barranco		25a. DATE REC'D. BY REGISTRAR Aug 26 1985	
25b. REGISTRAR'S SIGNATURE Severna Park, MD 21146			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES
POST OFFICE

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DEPT. OF AGRICULTURE



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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

225015

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence May Linthicum			2a. DATE OF DEATH MONTH DAY YEAR 8/4/85		2b. HOUR 6:15 A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1/5/1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co. MD.		
10. CITY OR TOWN OF DEATH Crownsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY A.A. 13c. CITY OR TOWN Pasadena 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7629 Paradise Beach Rd. 21122		
14. FATHER'S NAME John MIDDLE Magel		15. MOTHER'S MAIDEN NAME FIRST Augusta MIDDLE - LAST Grosscup			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) -		16b. SOCIAL SECURITY NO. 218-22-1972		17. INFORMANT Florence Kucha / Pasadena, Md. 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 19 84 to August 19 85 , that (I) (we) lost the deceased alive on 16 July 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William P. Jones, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-5-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jones, William P.		22e. ADDRESS 4837 Solomons Isl Rd. 20711			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial	23b. DATE 8-7-85	23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR McGully Funeral Home		3204 ^{SS} Mountain Road Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR AUG 8 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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225019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fritz Lofton			2a. DATE OF DEATH MONTH DAY YEAR Aug. 4, 1985			2b. HOUR A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 25, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 78		7. UNDER 1 YEAR # UNDER 24 HRS. HOURS MIN. 18		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 670 Americana Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Civil Service		
13a. STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Claude Lofton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Baskin's			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 459-09-0952	
17. INFORMANT ADDRESS Dovie S. Lofton - Same as #13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1) Dementia 2) Cerebral atherosclerosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 79 , to 8/4 , 19 85 , that (I) (we) last saw the deceased alive on 8/4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph N. Friend			DEGREE M.D.			22c. DATE SIGNED 8/17/85			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend			22e. ADDRESS 205 Ridgeley Ave Annapolis, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD			25a. DATE REC'D. BY REGISTRAR AUG 8 1985			25b. REGISTRAR'S SIGNATURE J. A. Burdson - Fordell				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

248024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTIE C. MACHANDE		7a. DATE OF DEATH MONTH DAY YEAR 8-28-85		7b. HOUR 4⁰⁰ AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 6, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Gambrills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jack Beall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Tayman		13e. STREET ADDRESS / ZIP CODE 2406 Rutland Road 21054			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-78-7629		17. INFORMANT ADDRESS Frank Machande, Jr. Gambrills, MD 21054			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular rupture		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior Myocardial Infarction 2-3 Days		
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Atherosclerotic Disease		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8-27 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 85 85 85			
22a. I certify that (1) this hospital attended the deceased from 8-27 1985 to 8-28 1985 that (2) I have last saw the deceased alive on 8-28 1985 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (21) and did not wait the body after death.							
22b. SIGNATURE Arnold G. Alexander M.D.				DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-29-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Arnold G. Alexander, M.D.				22e. ADDRESS 650 Ritchie Hwy. Severna Park, Maryland			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 30, 1985		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, Anne Arundel, MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home				25a. DATE RECEIVED BY REGISTRAR AUG 30 1985		25b. REGISTRAR'S SIGNATURE Wanda Davidson-Randall	

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) BEATRICE .(nmn) MAIORKA			20. DATE OF DEATH MONTH DAY YEAR AUGUST 24, 1985		2b. HOUR 752 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Odenton	
14. FATHER'S NAME FIRST MIDDLE LAST Guy Mitchell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Francisca Treolla		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Son) ADDRESS P.O. Box 851 Mr. Guy Maiorka Lockhart, Texas 78644	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS					
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/24/1985 to 8/24/1985 , that (I) (we) lost saw the deceased alive on 8-24-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Memody M.D.			DEGREE		22c. DATE SIGNED 8/24/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARSHAD R. NODY, M. D.			22e. ADDRESS 14 WILLIAM AVENUE, SUITE 103 GLEN BURNIE, MARYLAND 21061		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 29, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Dickinson, Galveston, Texas		24. FUNERAL DIRECTOR NAME R. S. Hopkins ADDRESS Singleton Funeral Home, Glen Burnie, Md. 21061			
25a. DATE REC'D. BY REGISTRAR AUG 27 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rodriguez			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOTTIE E. MARQUSS		2a. DATE OF DEATH MONTH DAY YEAR 8-29-85		2b. HOUR 6:33 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-23-1902	
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 82		8. IF UNDER 24 HRS HOURS MIN. 6:33 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Household		13a. STREET ADDRESS / ZIP CODE 3969 Germantown Rd.		13b. ZIP CODE 21037	
13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3969 Germantown Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Stallings		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Fowler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.	
16b. SOCIAL SECURITY NO. 579360308		17. INFORMANT Millie Svenson		17. ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable CVA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 81 to August 19 85 , that (I) (we) last saw the deceased alive on July 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Titlebaum					
22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Titlebaum					
22e. ADDRESS Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					
23b. DATE 9-4-85					
23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Cem.					
23d. LOCATION CITY OR TOWN COUNTY STATE Owings Calvert Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Home Annapolis, Md.					
25a. DATE REC'D. BY REGISTRAR SEP 4 1985					
25b. REGISTRAR'S SIGNATURE [Signature]					

BP

23082

RECEIVED + NOTICE FOR



W. A. P. A. H.



232123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21430					
1- FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JAMES Jacob MASON						8		8		85				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
male		White		Feb 25, 1904		81		YRS		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		USA				Anne Arundel Co., MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		508 Pafel Road				Retired		U.S. Navy							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
13a. STATE 13b. COUNTY 13c. CITY OR TOWN						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		508 Pafel Road- 21401							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
JOHN MASON						HARRIETT Virginia SIMMONS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Yes 1921-1947						213-28-4857		James D. Mason Annapolis, MD 21401							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION							
WHITE <input type="checkbox"/> AT WORK NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/5 19 85, to 8/8 19 85, that (II) (we) last saw the deceased alive on 7/5 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (and) not view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
EW Cole III				MD				8/9/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
EW COLE III				51 FRANKLIN ANNAP. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				Aug 12, 1985		Arlington National				Arlington Arlington VA					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Taylor Funeral Chapel-Annapolis, MD				AUG 16 1985											

MEDICAL CERTIFICATION

224044

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE NO. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

FOR ITEM NUMBER 4 STATE PER. PH. CALL REGISTRAR 8-2285 D.W.		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		21431 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ALLEN GARNETT MATTHEWS		2a. DATE KNOWN OF DEATH ESTIMATED 8 19 85		2b. HOUR M	
3. SEX M	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 2 54	6. AGE (IN YEARS) LAST BIRTHDAY 31 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 8-1-85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7d. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN CITY OR TOWN OF DEATH) EASTERN MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE AGENT	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN SEVERN	
14. FATHER'S NAME FIRST MIDDLE LAST ALFONSO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PHYLLIS QUEEN		16. INSURANCE AGENT METROPOLITAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-56-2121		17. INFORMANT ADDRESS DEBORAH MATTHEWS, 536 QUEENSTOWN ROAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8159 IMMEDIATE CAUSE (a) CRUSHING INJURY - CHEST DUE TO, OR AS A CONSEQUENCE OF (b) Auto ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:30 PM 8 1 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) CAR STRUCK TREE -	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Rte 50		21f. LOCATION CITY OR TOWN COUNTY STATE South of Innappe before Co Rd	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Louis S. Wolter		TITLE (SPECIFY) M.D. for Dep		DATE SIGNED 8-1-85	
EXAMINER'S NAME (TYPE OR PRINT) Louis S. Wolter		ADDRESS EASTON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-6-1985		23c. NAME OF CEMETERY OR CREMATORY SAINT REST CEMETERY	
24. FUNERAL DIRECTOR NAME UNIFUNER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PARKWAY		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL COUNTY		25a. DATE REC'D. BY REGISTRAR AUG 8 1985	
25b. REGISTRAR'S SIGNATURE R. Davidson-Randall					

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233118

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSIE KATE McLAUGHLIN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1985		2b. HOUR 1:05 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 25 23		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Super Market	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Yother		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Daugherty		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 413-12-1936	
17. INFORMANT Leonard Cholewa		18. ADDRESS Same as 13e		19. STREET ADDRESS / ZIP CODE 6866 B & A Blvd 21090			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 11 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-31 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 			
22a. I certify that (I) (this hospital) attended the deceased from 7-31 1985 to 8-13 1985 , that (I) (we) lost saw the deceased alive on 8-13 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Long S. Hsu		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, #104 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/16/85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Howard Md	
24. FUNERAL DIRECTOR George J. Gonca 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR AUG 15 1985			
				25b. REGISTRAR'S SIGNATURE Johia Davidson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

4

SECRET
U.S. AIR FORCE
OFFICE OF THE SECRETARY
WASHINGTON, D.C.
1954

TO: THE SECRETARY, AIR FORCE
FROM: THE SECRETARY, AIR FORCE
SUBJECT: [Illegible]



RECEIVED

226086

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON CARL MEYERS			2a. DATE KNOWN OF DEATH MONTH DAY YEAR AUG. 6 1985		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 9, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY SAFE COMPANY		13. STREET ADDRESS 801 TELEGRAPH RD. 21144	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS MEYERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA (UNKNOWN)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 216.18.4394		17. INFORMANT (BROTHER) ADDRESS MR. RAYMOND A. MEYERS SAME AS #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.U.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>William P. Jones, M.D.</u>		TITLE (SPECIFY) <u>Deputy</u> M.D.		DATE SIGNED <u>8/6/85</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>William P. Jones, M.D.</u>		ADDRESS <u>695 America Ct., Davidsonville, Md. 21035</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 9, 1985		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MD.		24. FUNERAL DIRECTOR NAME <u>SINGLETON FUNERAL HOME</u> ADDRESS <u>GLEN BURNIE, MD. 21061</u>			
25a. DATE REC'D. BY REGISTRAR AUG 9 1985		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>			

RECEIVED - 11/10/1910

11/10/1910

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235061

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>PATRICIA A. GEARY MILLER</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 - 17 - 85</i>		2b. HOUR <i>5:55A.M.</i>				
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i> <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 15 27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Connecticut</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>Crofton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1508 Elwyn Avenue</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Crofton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1508 Elwyn Ave.</i> 21114	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Matthew F. Geary</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Leary</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>047-22-7446</i>		17. INFORMANT <i>William V. Miller</i>		ADDRESS <i>same as 13e</i>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardio pulmonary arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

*Metastatic Ovarian Carcinoma**2 1/2 yrs*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*2° Hepato renal Failure*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *none*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>none</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>19 85</i> to <i>August 17 19 85</i> , that (I) (we) last saw the deceased alive on <i>August 17 19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ronald C. Sroka MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-17-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RONALD C. SROKA.</i>		22e. ADDRESS <i>3 VILLAGE GREEN CROFTON, MD</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Aug. 17 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory, Alexandria, Virginia</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>21114</i>	
24. FUNERAL DIRECTOR NAME <i>Beall Funeral Home</i>		ADDRESS <i>16000 Annapolis Road Bowie, Maryland</i>		25. INTERVIEWED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8-11-8



Hand-drawn diagram of a rectangular structure with internal lines, possibly representing a building or a container.



8-11-8

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Hand-drawn diagram of a rectangular structure with internal lines, possibly representing a building or a container.

Hand-drawn diagram of a rectangular structure with internal lines, possibly representing a building or a container.

240084

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PEGGY L. MITCHELL			2a. DATE OF DEATH MONTH DAY YEAR 8-17-85		2b. HOUR 6:48 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8-31-1921		6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Household	
13a. STATE Md.	13b. COUNTY AACo.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3734 Ramsey Dr. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST Hence Stroud		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian C. Kidd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-12-6831		17. INFORMANT Charles W. Mitchell ADDRESS Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular of the LowerAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**1 year**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/15 19 85 , to 8/17 19 85 , that (I) (we) last saw the deceased alive on 8/17 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE EW Cole III	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/17/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EW COLE III		22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-21-85	23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AACo. Md.
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS Annapolis, Md.	25a. DATE REC'D. BY REGISTRAR AUG 26 1985
		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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246125

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALLAN G. MOORE			2a. DATE OF DEATH MONTH 8 DAY 28 YEAR 85		2b. HOUR 6:30 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DECEMBER DAY 15 YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ARNOLD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 977 MAGOTHY ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINISTER	12b. KIND OF BUSINESS OR INDUSTRY CHURCH	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ARNOLD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 977 MAGOTHY ROAD 21012	
14. FATHER'S NAME FIRST WILLIAM MIDDLE K. LAST MOORE		15. MOTHER'S MAIDEN NAME FIRST ELSIE MIDDLE LAST KNAUSS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218-10-3444		17. INFORMANT ADDRESS JANE MOORE 977 MAGOTHY ROAD 21012	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **Stroke**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **hypertension**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASCVD**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 8, 1980 to Aug 28, 1985 , that (I) (we) last saw the deceased alive on 8/23, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Antonia Plucis		DEGREE MD		22c. DATE SIGNED 8/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Antonia Plucis, Md.		22e. ADDRESS 1521 Ritchie Highway			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8/28/85	23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS	23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVENUE	25a. DATE REC'D. BY REGISTRAR AUG 30 1985
		25b. REGISTRAR'S SIGNATURE [Signature]	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM-5 (CERTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS ELDRIDGE MORELAND, SR.				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Y 17 19 85				2b. HOUR 1000-1200M	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 6 03	6. AGE (IN YEARS) (LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 8 17 19	2d. HOUR 1830M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD - US		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10. CITY OR TOWN OF DEATH Lothian		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 274 BAYARD ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer		12b. KIND OF BUSINESS OR INDUSTRY farming	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Lothian		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 274 Bayard Rd. 20711	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace B. Moreland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alvira Wilkerson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Tom Moreland		17b. TOWN-COUNTRY BLD Ellicott City, MD 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Chr Guy Ht Failure - years DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE J. E. Wheeler				TITLE (SPECIFY) Dep		MEDICAL EXAMINER 1116 Gumbottom Road		DATE SIGNED 8-17-85	
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.				ADDRESS Crownsville 21032					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Lothian AA MD			
24. FUNERAL DIRECTOR NAME ADDRESS Rausch Funeral Home Owings, MD				25a. DATE REC'D. BY REGISTRAR Aug 26 1985		25b. REGISTRAR'S SIGNATURE David R. Riddle			

226034

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETTY ODELL MORGAN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10, 1985		2b. HOUR 930 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 11 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Line Operator	12b. KIND OF BUSINESS OR INDUSTRY Bendix	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7812 Water Oak Pt. Rd. 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Lee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST =====			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 28 4774		17. INFORMANT ADDRESS George Morgan (Husband - same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole DUE TO, OR AS A CONSEQUENCE OF (b) Massive myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) 78111 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 10 , 19 85 , to Aug 10 , 19 85 , that (I) (we) lost N.A. Aug 10 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.					
22b. SIGNATURE Benjamin James J., M.D.		DEGREE M.D.		22c. DATE SIGNED 8/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN JAMES J., M.D.		22e. ADDRESS 653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8 11 1985	23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.
24. FUNERAL DIRECTOR NAME George Gonce		ADDRESS 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR AUG 12 1985	
				25b. REGISTRAR'S SIGNATURE John W. Anderson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

221129

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LOLA M. NELSON			2a. DATE OF DEATH MONTH DAY YEAR 8/1/85		2b. HOUR 10¹⁴ PM						
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6/26/17		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A.S.H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY AA		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 125 CHANSON PLACE 21401		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES NELSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA NELSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-1883		17. INFORMANT Annapolis, Md. 21401 DORETHA FOWLKES 12 Johnson Place							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute leukemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. B. Bledsoe			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-5-1985		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland				
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401						25a. DATE REC'D. BY REGISTRAR AUG 7 1985 25b. REGISTRAR'S SIGNATURE J. Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Virginia Norris			2a. DATE OF DEATH MONTH DAY YEAR August 10, 1985			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Gambrills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Author D. Long				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen M. Lloyd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-03-2320		17. INFORMANT ADDRESS Chester V. Norris 13e			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> 19 <u>76</u> to <u>Aug 10</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Jan 1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>James J. Rhodes MD</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>8/12/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P RHODES MD</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial		23b. DATE 8-13-85		23c. NAME OF CEMETERY OR CREMATORY Louden Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME T.A. Hardesty				25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE <u>James J. Rhodes</u>	

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST DELLA	MIDDLE M	LAST OAKS	2a. DATE OF DEATH MONTH DAY YEAR 08-04-85		2b. HOUR 6 ³⁰ A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 15 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN DAVIDSONVILLE		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST FLOYD L. BOWLIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DRUSILLA PRATT		16. STREET ADDRESS / ZIP CODE 3052 LAKE DRIVE 21035				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-26-7144		17. INFORMANT ELAINE OAKS RIVA, MD. 21140				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1984, 19, to 8/4/85, 19, that (we) lost saw the deceased alive on 8/3/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE SP. W. Atkins - Dr. S. Selovick DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 8/4/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WATKINS - STUART SELOVICK				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-7-85		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A.CO. MD.		
24. FUNERAL DIRECTOR ROBERT E. EVANS 1212 WEST STREET ANNAPOLIS, MARYLAND						25a. DATE REC'D. BY REGISTRAR AUG 10 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Statistical data

2210933

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21442

FOR
STATE
REGISTRAR

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARA A. OGLE		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 5, 1985		2b. HOUR 11:05 A M	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 3 1894		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Anne Arundel		13c CITY OR TOWN Millersville,	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Booker		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Raglar		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 218-10-5612		17 INFORMANT Rt. 3-Box 7-Haven St., Denton, Md. #21629	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from July 8, 1985 to Aug. 5, 1985 , that (I) (we) last saw the deceased alive on Aug. 4, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b SIGNATURE Charles J. Wu		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Aug. 6, 1985	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D.		22e ADDRESS 7845 OAKWOOD ROAD #204 GLEN BURNIE, MARYLAND 21061					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 8, 1985		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery Balto.		23d LOCATION CITY OR TOWN COUNTY STATE Md.	
24 FUNERAL DIRECTOR G. Irman Schwab		5151 Balto. Nat'l. Pike #21229		25a DATE REC'D. BY REGISTRAR AUG 7 1985		25b REGISTRAR'S SIGNATURE John Davidson-Henderson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED

NOV 20 1950

100-100000

100-100000



228118

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21443
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P
August 2, 1985 11:10 M1. DECEASED NAME FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P
MARGARET Ourand
3. SEX FEMALE 4. RACE CAUCASIAN 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS.
JAN. 20, 1886 99 YRS MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☐ NEVER MARRIED ☒ 9. BALTIMORE CITY OR COUNTY OF DEATH
WASHINGTON, D.C. UNITED STATES WIDOWED ☐ DIVORCED ☐ ANNE ARUNDEL MD10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE NORTH ARUNDEL CONVELESCENT CTR RETIRED TEACHER D.C. PUB. SCHOOLSUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE
MARYLAND ANNE ARUNDEL SEVERNA PARK YES ☐ NO ☒ 802 W. BENFIELD RD. 2114614. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CHARLES HENRY Ourand AMELIA SKERRET16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS
NO — JANE O. SMITH (SAME AS 13)18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) CVA
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lastPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Arteriosclerosis19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐ YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
P.M. 1921d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐22a. I certify that (I) (this hospital) attended the deceased from 5-10, 1983, to 8-2, 1985, that (I) (we) last saw the deceased alive on 7-28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.22b. SIGNATURE DEGREE 22c. DATE SIGNED
Mustafa C OZ MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 8-2-8522d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS
Mustafa C OZ MD 605 S-A 1 Blvd S.P. MD 2114623a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL August 6, '85 Rock Creek Cemetery WASHINGTON D.C.24. FUNERAL DIRECTOR NAME 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
BARRANCO FUNERAL HOME 551 RITCHIE HWY. SEVERNA PARK, MD AUG 08 1985 John Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

232028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM CURTIS OWENS, Sr.			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1985			2b. HOUR P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 3, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH PASADENA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 633 TEBBSTON DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LOCAL #16 (ret)	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RUPERT B. OWENS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE F. WOOD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ?		17. INFORMANT (Son) ADDRESS 320 S. Carolina Ave. WILLIAM C. OWEN, JR. Pasadena, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Acute Myocardial Infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>End stage Renal Disease on Dialysis; chronic obstructive lung disease.</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>85</u> , to <u>8/14</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>MD</u>		22c. DATE SIGNED 8/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARI K BHASIN MD PA		22e. ADDRESS 606 HAMMONDS LANE BALTIMORE MD 21225	

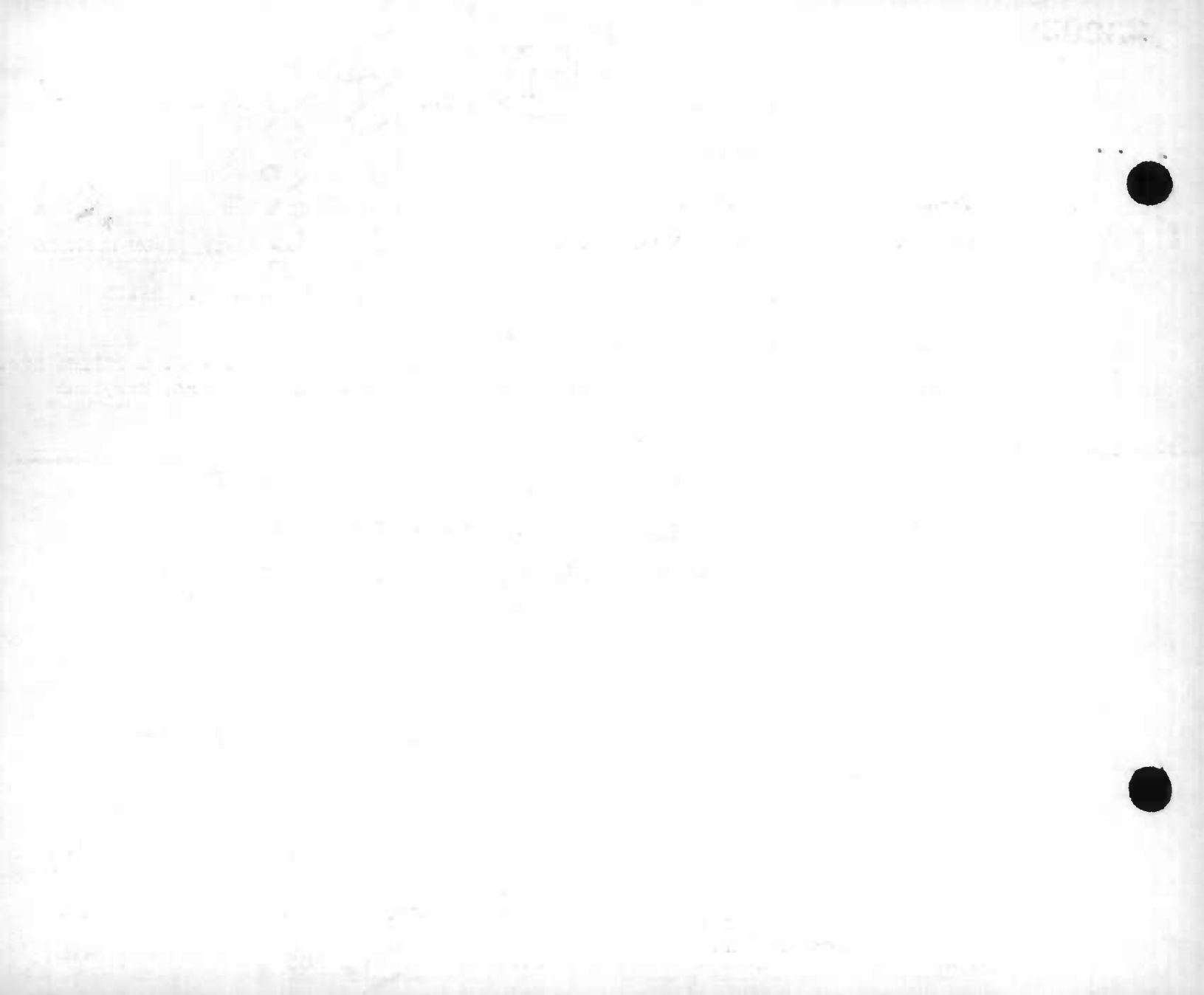
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 17, 1985		23c. NAME OF CEMETERY OR CREMATORY GERRARDSTOWN PRESBYTERIAN CH. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE GERRARDSTOWN W.V.	
24. FUNERAL DIRECTOR NAME ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061				25a. DATE REC'D. BY REGISTRAR AUG 15 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.



227029

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21445

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arthur William Parker			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC 19		
3. SEX Male	4. RACE Neg	5. DATE OF BIRTH MONTH 6 DAY 30 YEAR 84	6. AGE (IN YEARS) LAST BIRTHDAY 10 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Farming		MD.			
13a. STATE MD		13b. COUNTY A.A.	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 627 Queenstown Rd.
14. FATHER'S NAME FIRST Corey MIDDLE Parker LAST Parker		15. MOTHER'S MAIDEN NAME FIRST Matilda MIDDLE Parker LAST Parker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 214-05-1786		17. INFORMANT ADDRESS Mamie Parker - 627 Queenstown Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE William P. Jones		TITLE (SPECIFY) Deputy		DATE SIGNED 8/11/85	
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Crt., Davidsonville, Md. 21035			
23a. BURIAL, CREMATION, REMOVAL (BY) Burial	23b. DATE 8-15-85	23c. NAME OF CEMETERY OR CREMATORY St Rest		23d. LOCATION CITY OR TOWN COUNTY STATE Harmons A.A. Md	
24. FUNERAL DIRECTOR NAME Wm Pusey & Sons ADDRESS Annapolis, Md		25a. DATE RECD. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE William P. Jones	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANYBODY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Avenue" and "Street" are faintly visible.]



221070

1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

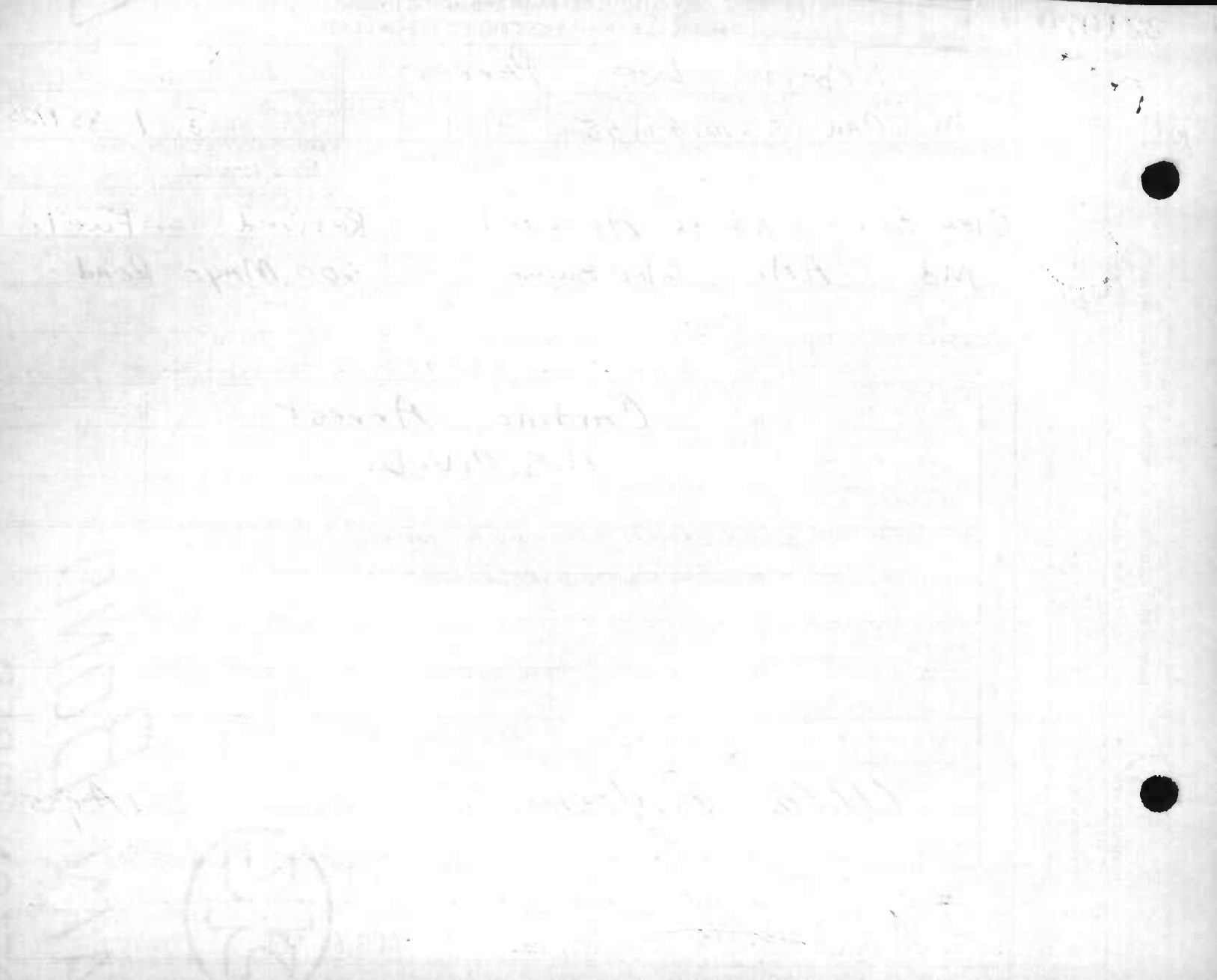
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Robert Lee Parker		X MONTH DAY YEAR Aug. 1 1985		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
M	White	Aug. 16, 1929	55 YRS.	MONTHS DAYS HOURS MIN.	MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
North carolina	U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRIAL
Glen Burnie	North Arundel		Office Manager (ret)		Parker Co.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
md	A.A.	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	600 Mayo Road.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Vida Parker		Lydia Dayton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		Korean ?		Mrs. Maxine E. Parker (wife) Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>A.S.C.U.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>William P. Jones, M.D.</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>1 Aug 85</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>William P. Jones, M.D.</u>		ADDRESS <u>695 America Crt., Davidsonville, Md. 21035</u>			
23a. BURIAL, CREMATION, REMOVAL DATE (SPECIFY) <u>Burial Aug. 7/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baily Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bakersville, Mitchell, N.C.</u>	
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home, Glen Burnie, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 7 1985</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1 AND 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



242110

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
PATSY J PENNINGTON		AUGUST 24, 1985		1000 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasion	7 9 1941	44	MONTHS 1 DAYS 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Frederick, Md.	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Housewife		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	A.A. Co	Glen Burnie	YES <input type="checkbox"/> NO <input type="checkbox"/>	2017 Norman Rd., 21061	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George Nelson		Viola Danner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-38-6384		2017 Norman Rd. John M. Pennington Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Melanotic Breast Cancer</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Panapopenia i Cachexia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-25</u> , 19 <u>85</u> , to <u>8-24</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8-24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>[Signature]</u>		M.D.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LONG S. ISUL M. D.		7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		8-26-85		Westview Crematory	
24. FUNERAL DIRECTOR		25. DATE RECEIVED BY FUNERAL DIRECTOR		25b. REGISTRAR'S SIGNATURE	
Raymond C. Fink Glen Burnie, Md. 21061		AUG 22 1985		<u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21448

EDT

1. DECEASED NAME (TYPE OR PRINT) Aka FIRST Hettie MIDDLE PENNY LAST Penny HATTIE PENNY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 14, 1985		2b. HOUR 110 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12 7 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurses aid	
12b. KIND OF BUSINESS OR INDUSTRY hospital					
13a. STATE Md.		13b. COUNTY A.A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST H John Caudill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Noralou			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 278 03 4180		17. INFORMANT ADDRESS John L. Penny (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Acute Coronary DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 80 , to Aug- 85 , that (I) (we) last saw the deceased alive on July 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Elmo M. Gayoso		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STATE PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELMO M. GAYOSO, M. D.		22e. ADDRESS 273-F PENINSULA FARM ROAD ARNOLD, MARYLAND 21012			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 8/16/85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	
23d. LOCATION Dorsey Howard Md.					
24. FUNERAL DIRECTOR NAME George Gonce		4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR AUG 19 1985	
25b. REGISTRAR'S SIGNATURE John L. Penny					

2000

242166

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert William Pommer			2a. DATE OF DEATH MONTH 8 / DAY 23 / YEAR 85			2b. HOUR 11:05 A							
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Aug. / DAY 19 / YEAR 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS / DAYS		8. IF UNDER 24 HRS. HOURS / MIN.			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.							
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3151 CATRINA LANE				12a. USUAL OCCUPATION (KIND OF WORK FOR MOST OF WORKING LIFE) Maritime Consultant-Civil Service			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.				13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3151 CATRINA LANE 21403			
14. FATHER'S NAME FIRST John MIDDLE F. LAST Pommer				15. MOTHER'S MAIDEN NAME FIRST FRANCES MIDDLE B. LAST Bauer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1944-1981 183-14-9360		17. INFORMANT ADDRESS Flora G. Pommer #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Melanoma, Metastatic DUE TO, OR AS A CONSEQUENCE OF (c) 6 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 1 , 19 85 to August 23 , 19 85 , that (I) (we) last saw the deceased alive on August 19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)													
22b. SIGNATURE Geoffrey Krystal MD.								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Geoffrey Krystal								22e. ADDRESS Bethesda Naval Hosp, Bethesda, Md 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/27/85		23c. NAME OF CEMETERY OR CREMATORY MD. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. MD.					
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis, MD								25a. DATE REC'D. BY REGISTRAR AUG 28 1985				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner or the medical examiner's office should be notified.

SACIAL

100% COTTON FIBER



100%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

225013

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) THELMA Ruth RAINS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 6, 1985		2b. HOUR 315 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 5, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena
14. FATHER'S NAME FIRST MIDDLE LAST ? UNKNOWN - - ?			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? UNKNOWN - - ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-70-4744		17. INFORMANT ADDRESS Florence Paul / 7788 Outing Ave. (21122)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral but faint					4 hours
DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarct					4 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/2 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/2 19 85 , to 8/6 19 85 , that (I) (we) last saw the deceased alive on 8/6 19 85 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE General Blum		DEGREE General		22c. DATE SIGNED 8/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD CRITCH, M.D.		22e. ADDRESS 8 EVERGREEN ROAD AT RIGGS AVENUE SEVERNA PARK, MARYLAND 21146			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Post Cem./Ft. G. Meade	
24. FUNERAL DIRECTOR NAME McCully Funeral Home		ADDRESS Mountain & Tick Neck Rds Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR Aug 8 1985	
25b. REGISTRAR'S SIGNATURE Richard Randall					

BP

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241038

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FANNIE L REED			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 25 1985		2b. HOUR 1215 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. STREET ADDRESS / ZIP CODE 1123 Crawford Rd 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Woosley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 417-28-9859	17. INFORMANT ADDRESS Patricia Cain 104 Baylor Rd., 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma reticulata</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sarcinoma</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/22/85</u> , 19 <u>85</u> , to <u>8/25</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert B. Koopnick</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/25/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KOOPNICK, M.D.		22e. ADDRESS 95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 27 Aug. 85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN Dorsey	STATE COUNTY Howard MD
24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie MD		25a. DATE REC'D. BY REGISTRAR AUG 27 1985		25b. REGISTRAR'S SIGNATURE <u>James S. Kirkley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked "at work" item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

NOV 19 1964



221098

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21452

1- FOR
STATE
REGISTRAR

REG. NO.

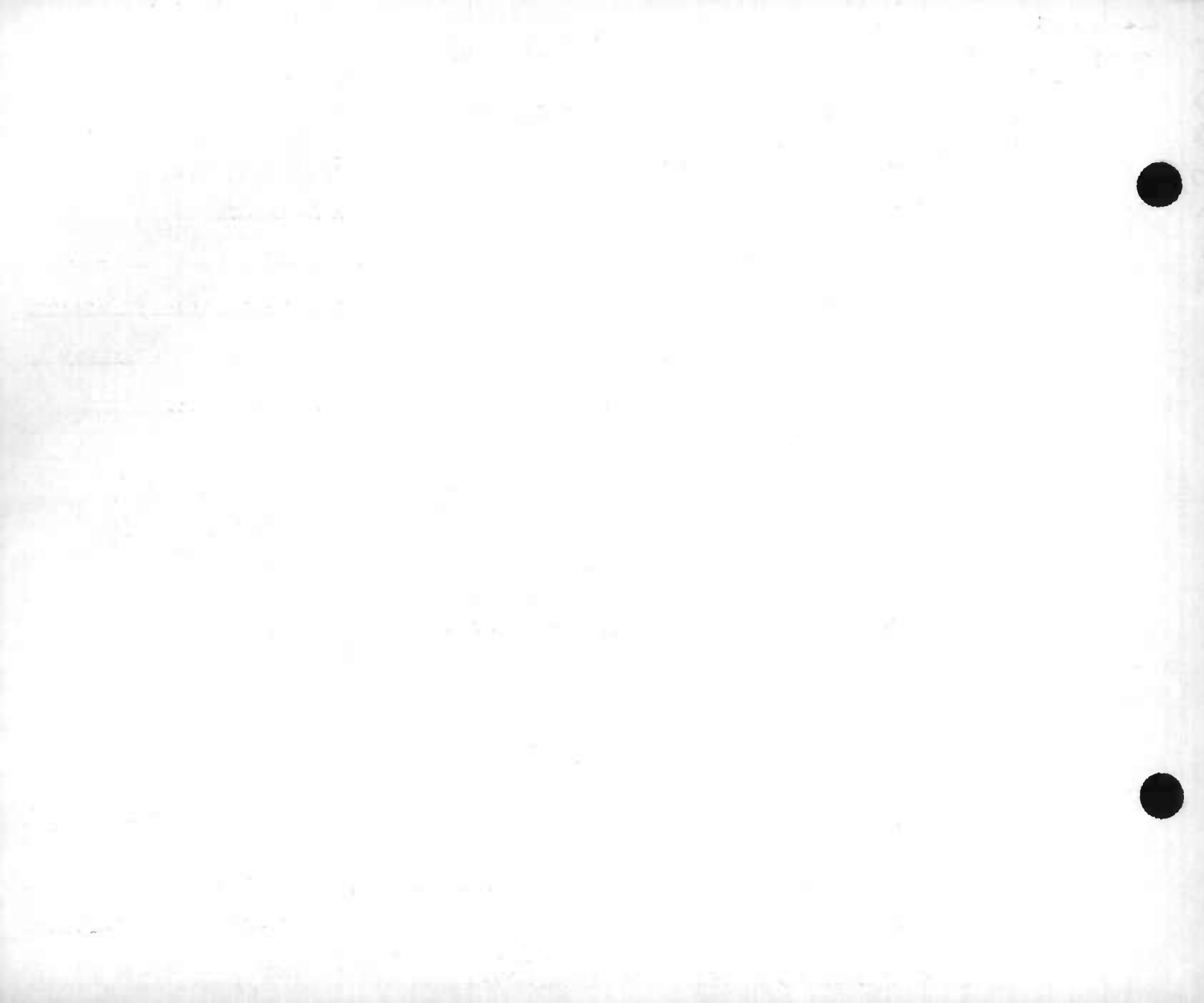
1. DECEASED NAME (TYPE OR PRINT) EDITH M. REINHARDT			2a. DATE OF DEATH MONTH DAY YEAR 8 4 85			2b. HOUR 10:30AM			
SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 13 01		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8181 ORCHARD POINT RD. 21122	
14. FATHER'S NAME FIRST MIDDLE LAST ELMER LUENBELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY BLACKBURN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-2326		17. INFORMANT ADDRESS CHARLOTTE GARNER 8306 Laico Ct. 21122				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) thrombosis of a descending aorta & distal blood vessel. DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION 8-4-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED thrombosis of abdominal aorta			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-3-85 , to 8-4-85 , that (I) (we) lost saw the deceased alive on 8-4-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H.R. Sunkara			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sunkara			22e. ADDRESS 14 Wellham Ave. Suite 203						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/7/85		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Maryland		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR AUG 7 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



225018

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21453

REG. NO.

DECEASED NAME (TYPE OR PRINT) RAMONA LEE RICHNER			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 8 YEAR 1985			2b. HOUR 1545		
1. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH Nov. DAY 19 YEAR 1960	6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH 8 DAY 2 YEAR 1985	2d. HOUR 1645		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		
13a. STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN Gambrells		
14. FATHER'S NAME Warren			15. MOTHER'S MAIDEN NAME Maxine			16. ADDRESS Young		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO, GIVE UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-84-5364			17. INFORMANT David A. Richner		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Brain Trauma; Fract Cerv. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Spine; Chest injury; multiple DUE TO, OR AS A CONSEQUENCE OF (c) fractures - Auto accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE James E. Wheeler			TITLE (SPECIFY) Dep			DATE SIGNED 8-2-85		
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.			ADDRESS 1196 Gumbottom Road Crownsville 21032					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD			25a. DATE REC'D. BY REGISTRAR AUG 8 1985			25b. REGISTRAR'S SIGNATURE [Signature]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 1266

DHMH - 17
(VR A15 ME (5))
20M 4/82

1. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The second part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The third part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The fourth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

2. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The second part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The third part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The fourth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

3. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The second part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The third part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The fourth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.



232145

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

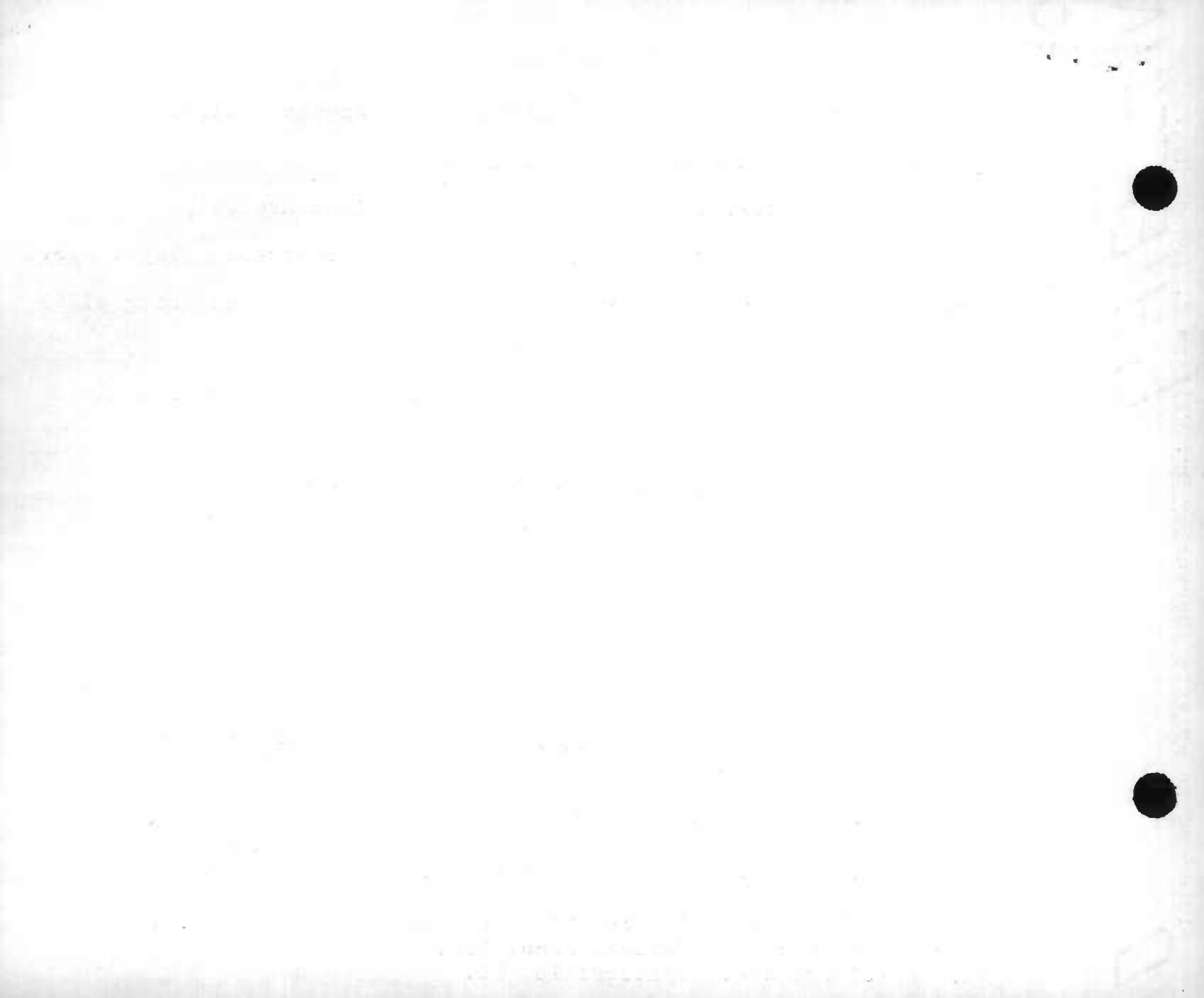
1. DECEASED NAME (TYPE OR PRINT) Jeanne Marie Ridley			2a. DATE OF DEATH MONTH DAY YEAR August 11, 1985		2b. HOUR M M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 21, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Odenton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1247-F Scott Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arun.		
13c. CITY OR TOWN Odenton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-686		17. INFORMANT 519 Monterey Avenue Moses A. Dyer, Odenton, Md. 21113	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural DUE TO, OR AS A CONSEQUENCE OF (b) ASHDC hypertension DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/23/85 , 19 85 , to 7/23/85 , 19 85 , that (I) (we) lost saw the deceased alive on 7/23/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Oscar A. Farias, M.D. DEGREE				22c. DATE SIGNED 08-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oscar A. Farias, M.D.				22e. ADDRESS 1667 Crofton Center, Suite 1 Crofton, Maryland 21114	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-16-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 16 1985	
25b. REGISTRAR'S SIGNATURE <i>Wardson-Wardson</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's assistant should be notified of office.

BP _____



232128

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLIS		FIRST MIDDLE LAST Purgeson Riley		2a. DATE OF DEATH MONTH DAY YEAR 8/19 8 14 85		2b. HOUR MIN. 4:15 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 11 1902		6. AGE (IN YEARS) (LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH CASE, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CABINET MAKER		12b. KIND OF BUSINESS OR INDUSTRY RET.	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. RILEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ellen League		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 03 4798	
17. INFORMANT ADDRESS Agnes R. Riley #13							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease - severe DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Yrs Yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe COPD			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE Joseph N. Friend		22c. DATE SIGNED 8/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend		22e. ADDRESS 205 Ridgely Ave Annapolis, Md.			

23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		23b. DATE 8-17-1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION CITY OR TOWN ANNAPOLIS	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		24. ADDRESS Annapolis MD		25. DATE REC'D. BY REGISTRAR AUG 16 1985		26. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and one of the following actions must be taken:

Handwritten notes, mostly illegible due to fading and bleed-through. Some legible fragments include:

- Top left: "1/2" and "1/4"
- Top center: "1/2" and "1/4"
- Top right: "1/2" and "1/4"
- Middle left: "1/2" and "1/4"
- Middle center: "1/2" and "1/4"
- Middle right: "1/2" and "1/4"
- Bottom left: "1/2" and "1/4"
- Bottom center: "1/2" and "1/4"
- Bottom right: "1/2" and "1/4"

224021

Items 18a 12/11/85 mth F#610

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21456

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Gary K. Rivers								8-6		19 85		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR
Male	Black	Nov. 30, 1946		38 YRS.					8-6		19 85		11:04 a.m.
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Anne Arundel County, MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME)		12b. KIND OF BUSINESS OR INDUSTRY							
Ft. Meade		Kimbrough Army Hospital		Calvert Dist.		Distillery							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		N/A		Baltimore				736 S. Woodington Rd.		21229			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Vincent Troy Rivers, Sr.		Ruby Bond											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		214-50-1095		Carolyn Rivers		736 S. Woodington Rd.		21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ethanolism</u> Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED		8-7-85							
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md.		21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		8/12/85		Garrison Forest		Owings Mills, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGIST.		25b. REGIST. SIGNATURE							
Leroy O. Dyett		4600 Liberty Hghts. Ave.		AUG 8 1985		Julia Davidson-Randall							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

242175

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21452

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie E. Roberts			2a. DATE OF DEATH MONTH DAY YEAR 8-20-85			2b. HOUR 5:40 AM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4-29-95		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co MD.			
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY @ Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1454 Fairfield Loop 21032	
14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard V. BRITNER				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret E. Ness					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No				16b. SOCIAL SECURITY NO. 246098009		17. INFORMANT 485 WHITE PLAINS CT SEV. PK MARGARET R. HOEFELICH 21146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.U.D. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Renal Failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12 Jul 1985 to Aug 1985 , that (I) (we) last saw the deceased alive on 19 Aug 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William P. Jones, MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 8-20-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, MD						22e. ADDRESS FAIRFIELD NURSING HOME			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/23/85		23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE ASHVILLE - N.C.		
24. FUNERAL DIRECTOR NAME DARRANCO F. H.						25a. DATE REC'D. BY REGISTRAR NOV 20 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or cremation. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Amie E. Roberts

8-24-17

Female

6-20

9-29-92

20

Wapiti

U.S.

X

Greenwich

1-1-17

Wapiti & Wapiti

Carac Arrow

1920

Green Arrow

Wapiti

1917

20

Green Arrow

249020

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		21450	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST John Daniel Ross		MONTH DAY YEAR HOUR 8 28 85 1:50 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
M	W	MONTH DAY YEAR 12 28 06	78 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Ohio	USA		A.A.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie	8077 Green Orchard Road	Sales	Design
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MD	AA	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST MIDDLE LAST Unknown	FIRST MIDDLE LAST Unknown	8077 Green Orchard Rd. #11	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
No	379 03 6764	Dorothy H. Ross same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>			<u>1 hr</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive Coronary Artery Disease</u>			<u>1 year</u>
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Chronic Renal Failure</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1984</u> , to <u>Aug 28, 1985</u> , that (I) (we) lost the deceased alive on <u>Aug 28, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.			
22a. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
<u>Hilary T. O'Herlihy</u>			<u>8/28/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
<u>Hilary T. O'Herlihy MD</u>	<u>325 Hospital Dr. Glen Burnie</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	08/29/1985	Green Mount Crematory	Baltimore City, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
<u>Walter Brooks Bradley, Inc. Balto., MD 21222</u>	<u>SEP 3 1985</u>	<u>John Davidson</u>	

220054

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21459

EDT

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH SANNER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 2, 1985		2b. HOUR 600 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 13, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service Ft. Meade		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY AACo.		13c. CITY OR TOWN Gambrills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 43 866 Maple Rd. 21054	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Wallace Stansfield				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ladellia Ambrosia Marr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-12-7678		17. INFORMANT ADDRESS Alpheus F. Sanner Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed Immed	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) grow negative x-ray									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 1, 1985 to August 1, 1985 that (I) (we) last saw the deceased alive on August 1, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE IRA KAPLAN		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA KAPLAN, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-4-85		23c. NAME OF CEMETERY OR CREMATORY Baldwin Meth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville AACo. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Futral Home Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR AUG 6 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

1-11-11 10:00 AM

1-11-11 10:00 AM

1-11-11 10:00 AM

(52)

1-11-11 10:00 AM

1-11-11 10:00 AM

1-11-11 10:00 AM

1-11-11 10:00 AM

1-11-11 10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted to the hospital or attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbonized copies of pages 1 and 2 and send them to the funeral director. The funeral director must completely fill in by the funeral director, page 3 and 4. The funeral director must also send page 1 and 2 to the health department. Page 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST EVA		MIDDLE M.	LAST SCONES		2a. DATE OF DEATH MONTH DAY YEAR			7 26 85		2b. HOUR 4:30		A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 7 32		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD									
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 204 Summit Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.						13b. COUNTY A. Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 204 Summit Ave. /23 21061			
14. FATHER'S NAME FIRST MIDDLE LAST John E. Benoit				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Peck											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-34-8872		17. INFORMANT Mr. Charles Scones						ADDRESS Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Artery thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>6-4-84</u> to <u>7-9-85</u> , that (I) (we) lost the deceased alive on <u>7-9-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Jon Porman MD</u>		DEGREE		22c. DATE SIGNED <u>7/31/85</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jon Porman MD</u>		22e. ADDRESS <u>2010 Ritchie Hwy Glen Burnie Md</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>7/26/85</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME ADDRESS <u>Anatomy Board Balto... Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 13 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Pandora</u>									



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

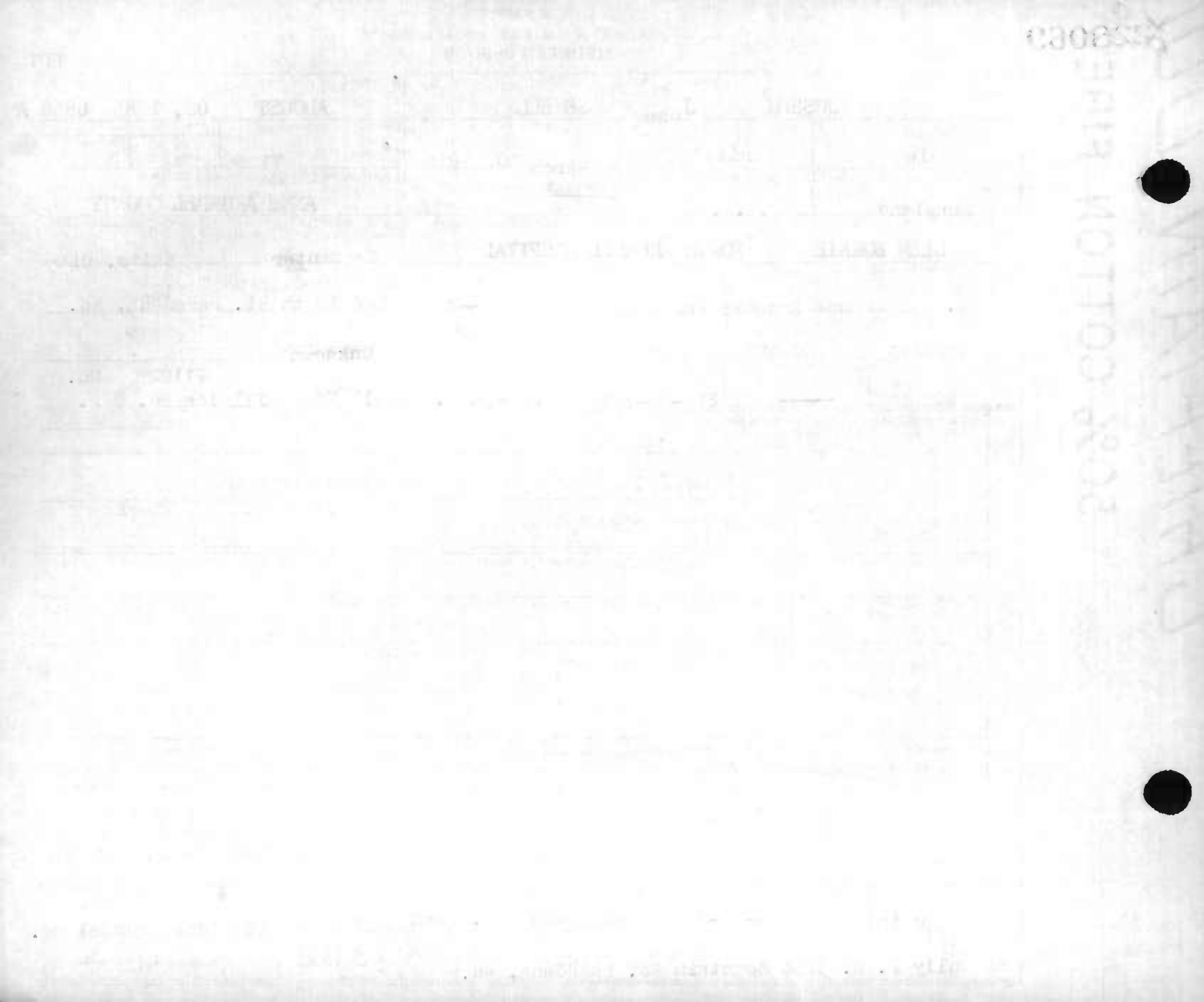
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				EDT			
1. DECEASED NAME (TYPE OR PRINT) JOSEPH John SEWELL				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 08, 1985				2b. HOUR 0850 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 10 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Balto. City			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Sewell				15. MOTHER'S MAIDEN NAME MIDDLE LAST Unknown ?				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 215-05-7713				17. INFORMANT ADDRESS (Son) 21122 Md. Joseph W. Sewell 1242 Hillside Rd. Pas.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/30 19 80, to 8/8 19 85, that (I) (we) lost saw the deceased alive on 8/3 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE S. Munda				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MUNDRA MD				22e. ADDRESS 203 E PATAPSCO AV BALTIMORE MD 21225							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-12-85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md.			
24. FUNERAL DIRECTOR NAME Mc Cully F. H. 3204 Mountain Rd. Pasadena, Md.				ADDRESS 21122		25a. DATE REG'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Wardle			

20% COTTON KID

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN EDWARD SEYMOUR, Jr.			2a. DATE OF DEATH MONTH DAY YEAR August 24, 1985		2b. HOUR M AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 6, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7d. CITIZEN OF WHAT COUNTRY? United States		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH Severna Park,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 737 McCann Rd. (21146)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov't. - Federal	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park	
14. FATHER'S NAME FIRST MIDDLE LAST John Edward Seymour, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve (Genny) - Bartnick		16. STREET ADDRESS 737 McCann Rd. (21146)	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 219-12-5446		17c. INFORMANT ADDRESS Shirley Seymour / Severna Park, Md. 21146	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 6 months					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael N. Peters		DEGREE MD		22c. DATE SIGNED 8/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael N. Peters		22e. ADDRESS 171 Defense Hwy Annapolis, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 27, 85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Cem.	
23d. LOCATION CITY OR TOWN Howard Co., Md.		23e. STATE MD.			
24. FUNERAL DIRECTOR NAME McCully Funeral Home / Mountain & Tick Neck Rd. Pasadena, Md. 21122					
25. DATE REC'D. BY REGISTRAR AUG 27 1985					

BP

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242113

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

HDT

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH MARION SHAMER			AUGUST 21, 1985			250 PM		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR September 17, 1892	6 AGE (IN YEARS LAST BIRTHDAY) YRS. 92			7c. IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10 CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress-Housewife, Hom e.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Pasadena		
14 FATHER'S NAME FIRST MIDDLE LAST JOHN - FAHERTY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA - GARDNER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - - -		
16b. SOCIAL SECURITY NO. 213-74-3140			17 INFORMANT ADDRESS Lillian Taylor / 1051 Locust Lane. Pasadena, Md. 21122					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse Atherosclerosis with Colic</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 1 week 10 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 8/21/85 to 8/21/85, that (I) (we) last saw the deceased alive on 8/21/85, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (If (we) did not see the body after death.								
22b. SIGNATURE Elliott Gordaty M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/21/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT GORDATY, M.D.			22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 24, 85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE - - - Baltimore Co., Md.	
24 FUNERAL DIRECTOR NAME McCully Funeral Home/ Pasadena, Md. 21122			25a. DATE REC'D. BY REGISTRAR AUG 26 1985			25b. REGISTRAR'S SIGNATURE John Gordon Appell		

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

61348

232127

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21464

1. DECEASED NAME (TYPE OR PRINT) Louise King Shortt			2a. DATE OF DEATH MONTH DAY YEAR 8-15-85			2b. HOUR 2:50 A.M.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6 24 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Conv. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil SERVICE	
12b. KIND OF BUSINESS OR INDUSTRY R.T.							

13a. STATE md.		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1053 NORMAN DR. Annapolis	
14. FATHER'S NAME FIRST LAST HARRY F. KING				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE MARTIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 214 05 0317		17. INFORMANT ADDRESS MARYCHAIRE TYLER 740 D FAIRVIEW AVE ANNAPOLIS, MD. 21403			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic BREAST CANCER			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) CVA, vocal cord paralysis			1 1/2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)				

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from 3/15 , 19 78 , to 7/23 , 19 85 , that (ii) (we) lost saw the deceased alive on 7/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (ii) (did) (did not) view the body after death.							
22b. SIGNATURE W. Cole MD				DEGREE MD		22c. DATE SIGNED 8/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Enser W. Cole III				22e. ADDRESS 37 FRANKLIN ST. #420 Annapolis			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/18/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff		23d. LOCATION CITY OR TOWN COUNTY Annapolis AA MD.	
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL				ADDRESS ANNAPOLIS MD.		25a. DATE REC'D. BY REGISTRAR AUG 16 1985	
25b. REGISTRAR'S SIGNATURE J. Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

219006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY E. SHRYOCK			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 4, 1985			2b. HOUR 5 A.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar 19, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Anne Arund		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Crouse			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Horner			13e. STREET ADDRESS / ZIP CODE 600 Carolyn Rd. 21061			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Margaret Mayronne 600 Carolyn Rd. 21061				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio Pulmonary Arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Immed.

DUE TO, OR AS A CONSEQUENCE OF

(b) MYOCARDIAL INFARCTION

Immed.

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerosis

Years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Cerebrovascular disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. E. Kaplan MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5 Aug 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kaplan				22e. ADDRESS suite #200 Oakwood Professional Bldg. 21061			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/7/85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland	
24. FUNERAL DIRECTOR NAME Ambrose, Inc. 1328 Sulphur Spring Rd.				25. DATE REC'D. BY REGISTRAR AUG 5 1985		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



220013

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elsie Sklar			2a. DATE OF DEATH MONTH DAY YEAR 8-1-85			2b. HOUR 1:40 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-23-1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Dental Lab.	
13a. STATE Fla.			13b. CITY OR TOWN Brevard		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 198 Dorchester I. 99999		
14. FATHER'S NAME FIRST MIDDLE LAST David Berger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Klein					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 057-09-8087		17. INFORMANT ADDRESS Edith Dolgoff 1470 Grandview Rd. Arnold Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes Mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/23/85 to 8/1/85 , that (I) (we) last saw the deceased alive on 7/24/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James Chaconas			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/1/85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) James Chaconas			22e. ADDRESS 1521 Ritchie Hwy Arnold, Md 21012						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-2-85		23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AAcO. Md.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR AUG 6 1985		25b. REGISTRAR'S SIGNATURE Richardson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

E. 10055

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 1 4 6 7

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Frederick Douglas Smith								8/ 11/ 85				M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		14. HOUR	
M	B	June 16 1932		53 YRS.						8/11/ 1985		10:30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md		U.S.A.				Anne Arundel County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel General Hospital		Construction									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		14. STREET ADDRESS					
Md		A. A.		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21401 Forest Bench Rd					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Randolph Smith		Gertrude Colvert											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		Korean		212-30-3909		Larry F. Smith		454 Broadneck Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Multiple Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
8147				DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
		(c)											
PART 2 (OTHER SIGNIFICANT) CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		9:40 P.M. 8/11/19 85		pedestrian struck by auto									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION									
		roadway		Rt. 50 East of Whitehall Rd., Anne Arundel, Md.									
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Gregory R. Kauffman, M.D.		M.D. Assistant MEDICAL EXAMINER		8/12/85									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Gregory R. Kauffman, M.D.		111 Pem St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE			
Burial		8-18-1985		MTCALvary		Arnold		A.A.		md			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
E. E. Hicks III		1922 forest Drive		AUG 20 1985		[Signature]							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (1))
20M 4/82



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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SMITH GERTRUDE A. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 8 3 85		2b. HOUR 7:50 PM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12-24-10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY PBX
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN STEVENSVILLE	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BROWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGET MCCARTHY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 159-03-4165		17. INFORMANT ADDRESS GERTRUDE M. CRANE SAME AS 13E	

18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last**Pulmonary Embolism**

DUE TO, OR AS A CONSEQUENCE OF

Atherosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 PM 19 85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (If in this hospital) attended the deceased from 8/3/85 to 3/8/85 that I have last saw the deceased alive on 3/8/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22b. SIGNATURE Robert E. Evans MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 8-7-85	23c. NAME OF CEMETERY OR CREMATORY FRIENDS SOUTHWESTERN	23d. LOCATION CITY OR TOWN COUNTY STATE UPPER DARBY DELAWARE PENN.
24. FUNERAL DIRECTOR ROBERT E. EVANS		25a. DATE REC'D. BY REGISTRAR AUG 12 1985	
1212 WEST STREET ANNAPOLIS, MD. 21401		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES SMITH		2a. DATE OF DEATH MONTH DAY YEAR 08 01 85		2b. HOUR 5²⁰ PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 02 07 28	
6. AGE (IN YEARS LAST BIRTHDAY) 57		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 57 YRS.	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN HARWOOD	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4733 Sands Road 20776			
14. FATHER'S NAME FIRST MIDDLE LAST VERNON SMITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY SELLMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.11 219-30-6125		17. INFORMANT Harwood, Md. 20776 RUTH SMITH 4733 Sands Road	
18. CAUSE OF DEATH (Enter only one cause permitted for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung c DUE TO, OR AS A CONSEQUENCE OF, (b) Brain metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) was Sept 19 84 , to August 19 85 , that (I) was August 19 85 , saw the deceased alive on August 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.		22b. SIGNATURE Gary M. Richardson, M.D. DEGREE MD.	
22c. DATE SIGNED 8-2-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. RICHARDSON, M.D.		22e. ADDRESS 104 Forbes Street, Annapolis, Md. 21401	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-5-1985		23c. NAME OF CEMETERY OR CREMATORY LAKEMONT CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville A.A. Maryland		24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR AUG 1 1985	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

FOR 1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST ORVILLE	MIDDLE W	LAST SMITH	2a. DATE OF DEATH MONTH DAY YEAR AUGUST 21, 1985		2b. HOUR 705 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 19 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman		12b. KIND OF BUSINESS OR INDUSTRY Union Local		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Smith						15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ada Riggleman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-1512		17. INFORMANT ADDRESS Gary Smith Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Old C posterior completed stroke 6/2/85</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HASCVD with pulmonary edema 8/12/85</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Status-post mesenteric thrombosis 7-3-85; H/D abd. aneurysm</u>										
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>N/A</u>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 7</u> 19 <u>1985</u> , to <u>Aug. 21</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Aug. 21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Benjamin A. deGuzman, M.D.</u>		DEGREE		22c. DATE SIGNED <u>Aug. 21, 1985</u>				22d. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. DEGUZMAN, M.D.		22f. ADDRESS 325 HOSPITAL DRIVE SUITE 108 GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-24-85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY Glen Burnie A.A. Md.				
24. FUNERAL DIRECTOR LOCAL Glen Haven Funeral Home		24b. ADDRESS 237 E. Patapsco Ave. Balto. Md.		25a. DATE REC'D. BY REGISTRAR AUG 26 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall				

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified or contacted.

[The following text is extremely faint and largely illegible. It appears to be a handwritten document or a very poor quality scan of a printed document. The text is organized into several paragraphs and includes some numbers and possibly names, but the characters are too light to transcribe accurately.]

[Faint handwritten text, possibly a list or series of notes.]

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[Faint handwritten text, possibly a concluding paragraph or signature.]

246132

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21471

FOR
STATE
REGISTRAR

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) PAUL MADISON SNYDER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28, 1985			2b. HOUR 855 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 16, 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer -		12b. KIND OF BUSINESS OR INDUSTRY Farmer	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2905 Gladnor Rd. / 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Louis C. Snyder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda R. Coleman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - -		17. INFORMANT ADDRESS Mildred Ziegler / 2905 Gladnor Rd. (21122)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Basant K. Khandelwal				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDELWAL, M.D.				22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 31, 85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE - - Howard Co., Md.			
24. FUNERAL DIRECTOR NAME McCully Funeral Home / Pasadena, Md.				25. DATE RECD. BY REGISTRAR AUG 30 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

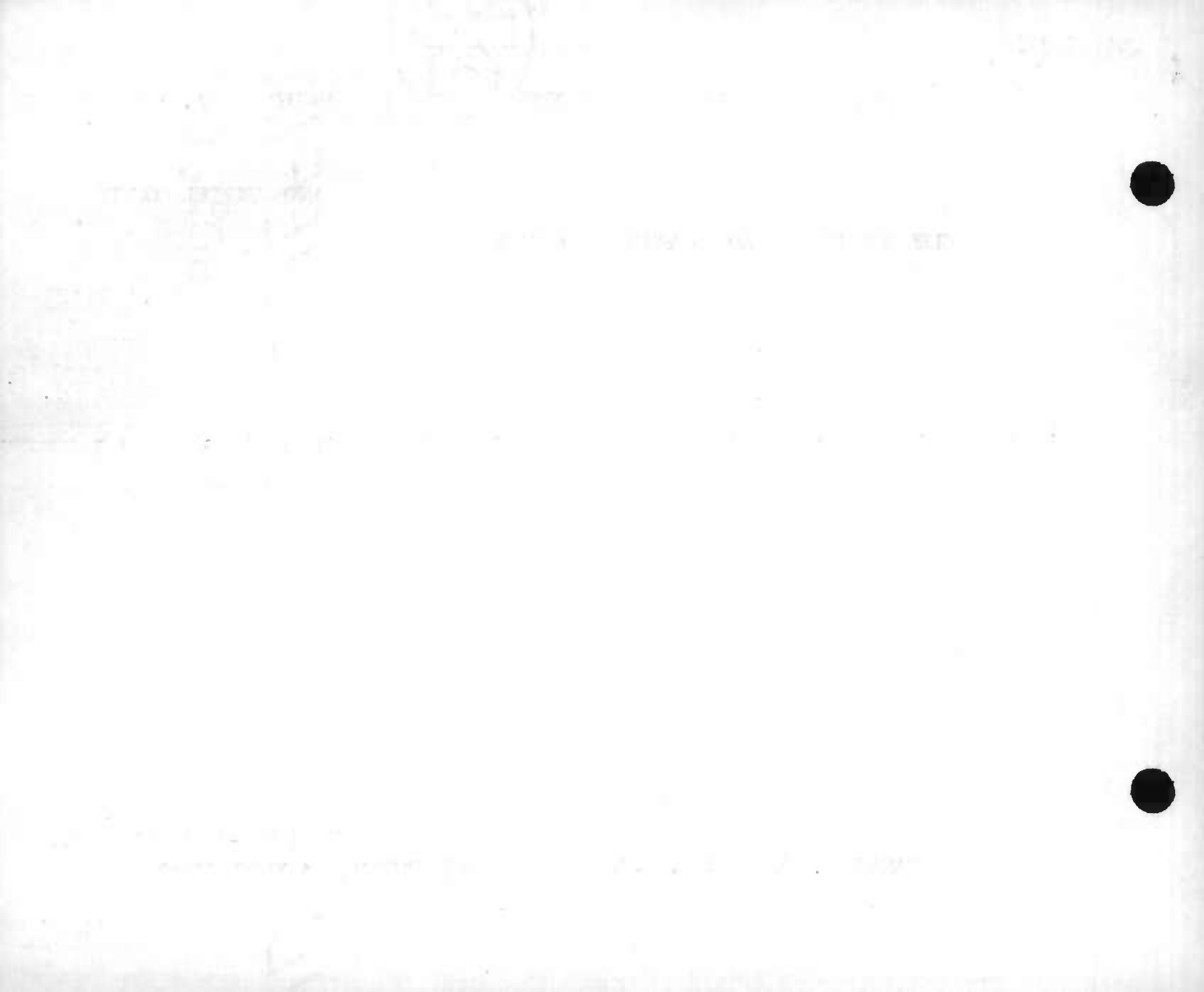
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

233083

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE SOIKA			2a. DATE OF DEATH MONTH DAY YEAR August 14, 1985		2b. HOUR 1:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 11 05		6. AGE (IN YEARS LAST BIRTHDAY) 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Arundel Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing
13a. STATE Maryland		13b. COUNTY A. Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Romecki		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalene Zakrzewska				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-10-5953		17. INFORMANT ADDRESS Joseph Soika, 678 West Shore Road Pasadena, Md. 21122		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of the brain DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) 1 year APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE August 2, 1985 August 14, 1985		
22a. I certify that (I) (this hospital) attended the deceased from June 2, 1985 to August 14, 1985 , that (I) (we) lost saw the deceased alive on August 14, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE R.M. McLaughlin, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. McLaughlin		22e. ADDRESS 3708 Mountain Rd. Pasadena, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-17-85		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.		23e. DATE REC'D. BY REGISTRAR AUG 19 1985		23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR Ann S. Matthews, Matthews Funeral Home 3021 Eastern Avenue, Baltimore, Md. 21224						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be written up by a doctor.

135083



trial 1-11-55 Holy Rosary Cemetery Holy Rosary Cemetery

101-1-11-55 (entry) 101-1-11-55

216022

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LENA G. STANTON			2a. DATE OF DEATH MONTH DAY YEAR 8. 24-85			2b. HOUR 0.55 ^A _M							
3. SEX female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1-11-24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. UNDER 1 YEAR MONTHS DAYS 0 0		7. UNDER 24 HRS HOURS MIN. 0 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21 Washington Drive 21401				
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES E. BOSTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE BROWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-24-5782			17. INFORMANT ADDRESS Albert Stanton 21 Washington Drive Annapolis, Md. 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR			
DUE TO, OR AS A CONSEQUENCE OF (b) Severe chronic obstr. respiratory Disease										25 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Sarcoidosis										25 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus; Congestive heart failure; Steroid dependency													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1975			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1833 Forest Drive Annapolis, Md. 21401							
I certify that (I) (the hospital) attended the deceased from July 1975 to Present , 19____, that (I) last lost saw the deceased alive on July 1975 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) move the body after death.													
22a. SIGNATURE Peter F. Verkouw						DEGREE			22c. DATE SIGNED 8/24/85				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUW						22e. ADDRESS 1833 Forest Drive Annapolis, Md. 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-29-1985			23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland				
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR AUG 27 1985							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner's signature is required on page 2. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

YOUNG LAMBERT COUNTY

A. B. A.

CHARTER

THE BOARD OF COUNTY COMMISSIONERS

MEMORANDUM

Washington, D. C.

1964

FROM

TO

SUBJECT

Amendment to the Charter of the Board of County Commissioners, Washington, D. C.

1

235162

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AMELIA M STEELE			2a. DATE OF DEATH MONTH 8 DAY 6 YEAR 85		2b. HOUR 3:30 ^{PM}
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 95	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN A NURSING FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND ANNE ARUNDEL CO. DAVIDSONVILLE			13a. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME FREDERICK A. MILLER			15. MOTHER'S MAIDEN NAME SASANA TACEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE UNKNOWN) NO (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 074-03-8325		
17. INFORMANT ADDRESS DOROTHY C. RYAN SAME AS 13E					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive heart failureAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**12 hours**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Atherosclerotic cardiovascular disease****15 years**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Possible myocardial infarction****12 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Deep venous thrombosis - 3 days.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 8/5 , 19 85 , to 8/6 , 19 85 , that (1) (we) last saw the deceased alive on 8/6 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert Scott Eden	DEGREE M.D.	22c. DATE SIGNED 8/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT SCOTT EDEN, M.D.	22e. ADDRESS 703 BIDDINGS AVE. ANNAPOLIS, MD. 21401		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8-9-85	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX CO VA
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS ANNAPOLIS, MARYLAND		25a. DATE REC'D. BY REGISTRAR AUG 16 1985	25b. REGISTRAR'S SIGNATURE Julie Davidson-Pondelle

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please detach the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

SHIPS

20% COLIC

CHIEFMAN

234128

FOR STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE ANN STEWART										2a. DATE KNOWN OF ESTI. DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR AUGUST 17 85 1420										2b. HOUR			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 29, 1908		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 77 YRS.		7. UNDER 1 YR. <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD AUGUST 17, 1985 1508										2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD											
10. CITY OR TOWN OF DEATH GLEN BURNIE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY OWN HOME											
13a. STATE VIRGINIA										13b. CITY OR TOWN CHESTERFIELD		13c. CITY OR TOWN RICHMOND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6732 COZY LANE		13f. ZIP CODE 23225					
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SAMUEL DODSON										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE MAE TANKSLEY													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 241-183-994		17. INFORMANT (SON) ADDRESS MR. DOUGLAS G. STEWART GLEN BURNIE, MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulm. arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Ch. heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <u>James E. Wheeler</u> M.D.										TITLE (SPECIFY) <u>Dr.</u>		MEDICAL EXAMINER <u>1116 Gumbottom Road</u> <u>Crownsville 21032</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>James E. Wheeler, M.D.</u>										ADDRESS <u>Crownsville 21032</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE AUGUST 20, 1985		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE RICHMOND HENRICO VIRGINIA									
24. FUNERAL DIRECTOR NAME <u>R. N. H. H. H.</u>										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>											
SINGLETON FUNERAL HOME GLEN BURNIE MARYLAND										AUG 20 1985													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STEWART
J. J. J. J.

STEWART

STEWART



BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BRADLEY WAYNE STIEGMANN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30, 1985		2b. HOUR 1100 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 - 16 - 47		6. AGE (IN YEARS LAST BIRTHDAY) 38	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OR GIVE MOST OF WORKING LIFE) manager	12b. KIND OF BUSINESS OR INDUSTRY Liquor Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 96 Willowbrook Dr. 21122	
14. FATHER'S NAME Clarence		15. MOTHER'S MAIDEN NAME Veronica		16. ADDRESS Wamhoff	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1986-1972 214-50-2280		17. INFORMANT Clarence Stiegmanna Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 8-20 , 19 85 , to 8-30 , 19 85 , that (I) (we) lost saw the deceased alive on 8-30 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) move the body after death.					
22a. SIGNATURE SANG C. DOH, M. D.		DEGREE MD		22c. DATE SIGNED 8-31-85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-3-85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE - Howard Co., Md.
24. FUNERAL DIRECTOR McCurly Funeral Home			25a. DATE REC'D. BY REGISTRAR SEP 4 1985		25b. REGISTRAR'S SIGNATURE John W. Wamhoff - Rode

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

011113

WEST 30.11.1944

WAVE AIRFIELD

WAVE AIRFIELD

WAVE AIRFIELD



WAVE AIRFIELD
WAVE AIRFIELD

WAVE AIRFIELD

232029

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) HELEN VIRGINIA STORZ			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 12, 1985			2b. HOUR M M				
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 16, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 76		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 706 OAK WOOD ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK (RET)		12b. KIND OF BUSINESS OR INDUSTRY CIVIL U.S. SERVICE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 706 OAKWOOD ROAD 21061	
14. FATHER'S NAME FIRST MIDDLE LAST GUY C. RIPLEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLIE P. EAKIN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A NONE				
16b. SOCIAL SECURITY NO. 218-22-0129			17. INFORMANT ADDRESS MR. JOSEPH W. STORZ (HUSBAND)			18. SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Old stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>organic Brain Syndrome</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>3-14</u> 19 <u>84</u> to <u>8-12</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>8-12</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and not) view the body after death.										
22b. SIGNATURE <u>Edward Sherman</u>					DEGREE ATTENDING MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8-13-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD SHERMAN, M.D.					22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MD. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUGUST 15, 1985		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME <u>B. H. H. H. H. H.</u> SINGLETON FUNERAL HOME, GLEN BURNIE, MARYLAND					25a. DATE REC'D. BY REGISTRAR AUG 15 1985			25b. REGISTRAR'S SIGNATURE <u>Richardson-Randall</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

PS0565

Order: ~~Old~~ ~~stems~~ ~~stems~~

TABLE 1

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

246128

1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John W. Swiderski						2a. DATE OF DEATH MONTH DAY YEAR 8-29-1985				2b. HOUR 5:50^{PM}	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 12 31 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 78 7 29		IF UNDER 1 YEAR MONTHS DAYS 7 29		IF UNDER 24 HRS HOURS MIN. 5:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 421 Irene Dr. Glen Burnie				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Foods			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Swiderski						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Shimkowiak					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT NAME ADDRESS Glen Burnie, Maryland 21061		17. INFORMANT NAME ADDRESS Marie Swiderski 421 Irene Drive					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles J. Wu.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>Aug. 30, 1985</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. Wu., M.D.				22e. ADDRESS 7845 Oakwood Road 21061 Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md. 21061						25a. DATE REC'D. BY REGISTRAR AUG 30 1985		25b. REGISTRAR'S SIGNATURE <i>John Gordon Fordell</i>			

MEDICAL CERTIFICATION

251375

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

249111

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ANN TATE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30, 1985		2b. HOUR 10:36A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 10 - 29		
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress -		
12b. KIND OF BUSINESS OR INDUSTRY Home-maker		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		
13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17921 East End Drive		
13f. ZIP CODE 21226		14. FATHER'S NAME FIRST MIDDLE LAST Howard		15. MOTHER'S MAIDEN NAME MIDDLE LAST Bersterman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Elizabeth Sylvester West End Drive Baltimore, Md. 21226		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septic Shock</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 5 hrs 12 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>entero cutaneous fistula / renal failure</u>						
19a. DATE OF OPERATION 8/08/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Barrel obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>8/08</u> 19 <u>85</u> , to <u>8/30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Constantine J. Padussis</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONSTANTINE J. PADUSSIS, M.D.		22e. ADDRESS 500 EMPIRE TOWERS 21061 7310 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-3-85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md		24. FUNERAL DIRECTOR 3204 Mountain Road McClary Funeral Home Pasadena, Md. 21122				
25a. DATE REC'D. BY REGISTRAR SEP 4 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>				

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EDT

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		YEAR		2b. HOUR	
DONALD		JAMES		THOMAS		SR.		AUGUST		13.		1985		215 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		JANUARY 20, 1908		77		YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U.S.A.				ANNE ARUNDEL COUNTY MD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		PLANT MANAGER		TIRE COMPANY									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
MARYLAND		A.A.		BROOKLYN PARK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		104 WEST 12th AVE. 21225							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
ORVILLE A. THOMAS				MATILDA J. McDONALD											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO N/A				212.07.6720				MRS. MARGARET E. THOMAS (WIFE)				SAME AS 13			
10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.															
IMMEDIATE CAUSE (a) metastatic disease															
DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma prostate -															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a															
Dress -															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED									
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		P.M. 19													
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. LOCATION		21h. LOCATION									
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/20/85, 19, to 8/13/85, 19, that (I) (we) lost saw the deceased alive on 8/13/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		77a. DATE SIGNED							
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS							
GEORGE B. RAMIREZ, M.D.		7845 OAKWOOD ROAD		GLEN BURNIE, MARYLAND 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
BURIAL		AUG. 17, 1985		MEADOWRIDGE MEM. PARK		ELKRIDGE		HOWARD		MARYLAND					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
NAME		AUG 15 1985		a. Davidson-Randall											
SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 60M 7/B4
(VRA 15, 4)

241051

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) HERMAN GILBERT THOMAS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 19, 1985			2b. HOUR 11:21 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 5 1920		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY CITY SCHOOLS	
13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN G. THOMAS, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE POOLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-7088		17. INFORMANT ADDRESS BEATRICE H. THOMAS, 437 ELLWELL CT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Seizure disorder, Diabetes</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (d) (did not) view the body after death.							
22b. SIGNATURE <u>Basant K. Khandelwal</u>		22c. ADDRESS 7422 BALTIMORE ANNAPOLIS BOULEVAR GLEN BURNIE, MARYLAND 21061		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDELWAL, M.D.		22e. DATE SIGNED 8/19/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-22-1985		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY	
24. FUNERAL DIRECTOR MUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PARKWAY				25a. DATE REC'D. BY REGISTRAR AUG 27 1985		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

341021



CHIEF

FOX-COTTON

THE BRIDGE, WATLAND ROAD

2022 JANUARY - APRIL 2022

220010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alice Geneva Thompson			2a. DATE OF DEATH MONTH DAY YEAR 8-2-85			2b. HOUR 1:50 M			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4-13-12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annie Arundel Gen				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietary Dept		12b. KIND OF BUSINESS OR INDUSTRY Institution	
13a. STATE md		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 49 LINCOLN ST 21401	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS ELMERLANDER MAKELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH MAKELL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-16-3272		17. INFORMANT ADDRESS CHARLENE G. WATKINS 49 LINCOLN ST ANNAPOLIS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of heart DUE TO, OR AS A CONSEQUENCE OF (b) metastasis to brain DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to 8/2/85 , 19____, that (I) (we) lost saw the deceased alive on 8/2/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stanley P. Watkins			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS MD					22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-5-1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem Garden		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD		
24. FUNERAL DIRECTOR NAME C.E. Nicks II			ADDRESS 1922 Forest Drive MD		25a. DATE REC'D. BY REGISTRAR AUG 6 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

010055



RECEIVED



10-16-55

Mr. J. Edgar Hoover
U. S. Department of Justice
Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT:

MEDICAL CERTIFICATION

240083

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ANNA		JEAN	TOBIN		AUGUST		17,	1985	9:40		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Cau		Jan. 17 1916		69		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		USA				Anne Arundel					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Odenton		1214 Howe Ct. 21113				Teacher		Education			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		A.A.		Odenton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1214 Howe Ct. 21113			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Thomas		McCloskey		Mabel		Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		301-16-9699		Bernard F. Tobin		13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>										1 Hour	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Metastatic Lung Cancer</u>										1 Year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to <u>17 AUG</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jonathan Safren MD</u>										22c. DATE SIGNED <u>19 AUG 85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan Safren M.D.										22e. ADDRESS KAMC Ft. Meade Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		8-21-85		Arlington Nat. Cem.		Arlington Va.					
24. FUNERAL DIRECTOR T.A. Hardesty						25a. DATE REC'D. BY REGISTRAR AUG 26 1985		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>			

Page 1 of 1



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther T. TRAVIS			2a. DATE OF DEATH MONTH DAY YEAR August 28, 1985		2b. HOUR 8:03 P.M.						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 18, 1911		6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24 Wardour Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. DATE Maryland						13c. COUNTY Anne Arundel		13d. CITY OR TOWN Annapolis		13e. STREET ADDRESS / ZIP CODE 24 Wardour Dr. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Haskell B. Talley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE Pearl Bartoff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-24-0187		17. INFORMANT Linda T. Osborn				ADDRESS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION February 6, 1980				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast, duct cell Carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 14</u> , 19 <u>80</u> , to <u>Aug. 28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Aug. 8</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles W. Kinzer								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 29, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, M.D.						22e. ADDRESS 16 Murray Ave., Annapolis, MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-29-85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Sutland PG. Md.					
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis, Md.						25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

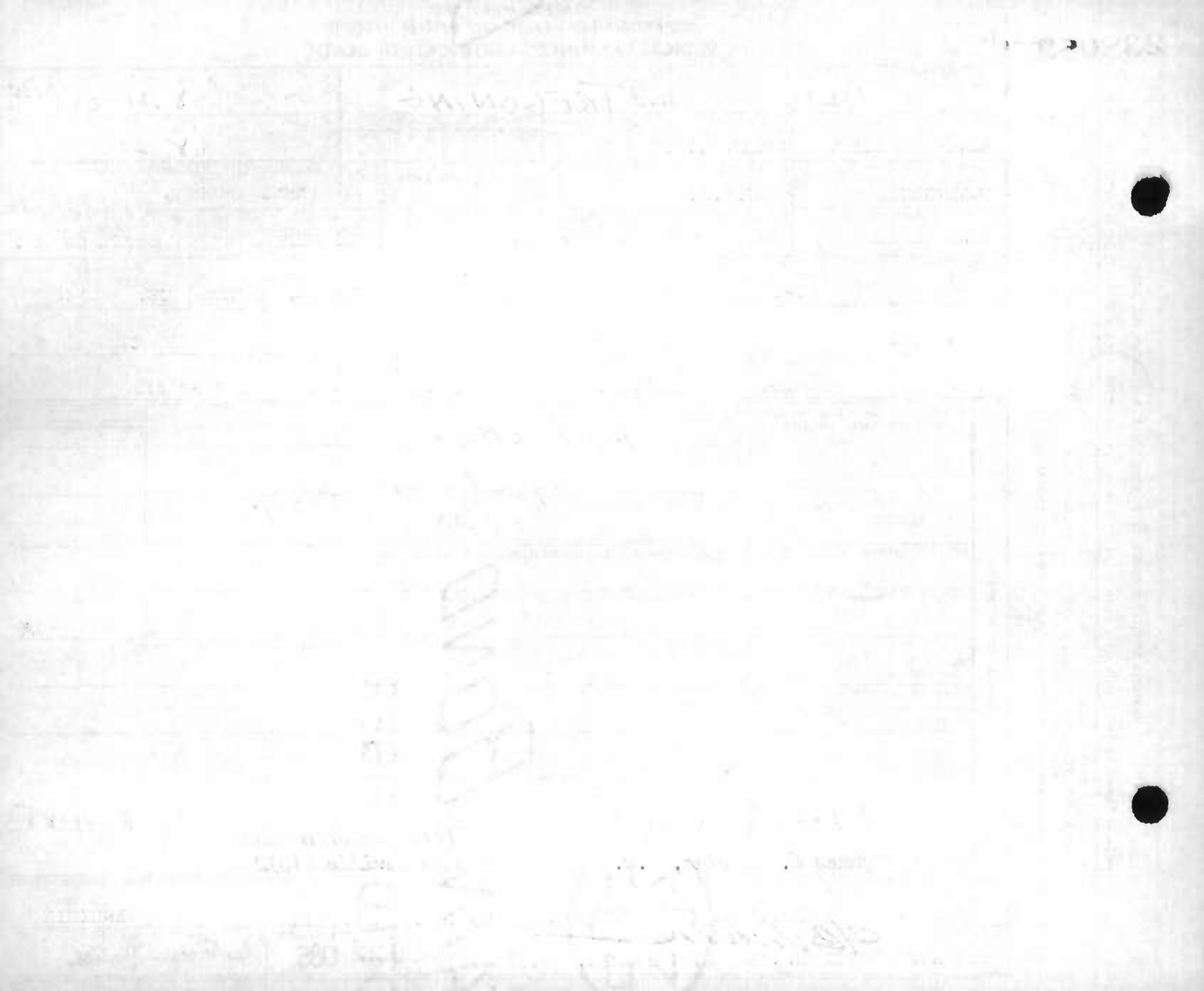
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





252084

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles W. Tucker			2a. DATE OF DEATH MONTH DAY YEAR 8-31-85		2b. HOUR MIN. 5:25 AM
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1890		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 95	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR INDUSTRY) Ret. worker		12b. KIND OF BUSINESS OR INDUSTRY Civil Service
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 89 Summerfield Drive 21403
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Tucker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolly Parkinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 11WWT 218-14-3017		17. INFORMANT ADDRESS Lillian E. Rayhart- same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cardiomegaly

DUE TO, OR AS A CONSEQUENCE OF

(c)

Dilated cardiomyopathy

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

renal failure, chronic obstructive Pulm Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 1983 to 8/31 19 85 that (i) (we) last saw the deceased alive on 8/30 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) see the body after death.			
22b. SIGNATURE George C. Samaras		22c. DATE SIGNED 8/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras		22e. ADDRESS 205 Ridgely Ave Annapolis, MD	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE Sept. 3, 1985	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis MD		25a. DATE REC'D. BY REGISTRAR SEP 5 1985	25b. REGISTRAR'S SIGNATURE Laurence Handell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and mail them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

241133

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21487

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Helen S. Tumolo			2a DATE OF DEATH MONTH DAY YEAR 8 23 85		2b HOUR 5:30 P M
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 3 29 03		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD	
10 CITY OR TOWN OF DEATH Millersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY - Home
13a STATE Maryland		13b COUNTY Anne Arundel	13c CITY OR TOWN Crofton	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Michael Corro		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Von Stankiwich			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - -		17 INFORMANT ADDRESS Helen J. Serini 1826 North Forest Court #D Crofton, Maryland 21114	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ISCHEMIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Renovascular hypertension, atherosclerosis</u>					
19a DATE OF OPERATION <u>N/A</u>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>8/22/85</u> to <u>8/23/85</u> , that (I) (we) lost saw the deceased alive on <u>8/22/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>M. K. Hodarantseva</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c DATE SIGNED <u>8/23/85</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. K. HODARANTSEVA</u>		22e ADDRESS <u>1101 Patapsco Avenue Baltimore, Maryland</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Aug 27, 1985	23c NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, MD	
24 FUNERAL DIRECTOR NAME <u>Keith L. Wadsworth</u>		ADDRESS <u>16000 Annapolis Road Bowie, MD 20715-3043</u>		25a DATE REC'D. BY REGISTRAR <u>AUG 27 1985</u>	
25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

212006

1. DECEASED NAME (TYPE OR PRINT) George H. Vincent			2a. DATE OF DEATH MONTH DAY YEAR August 22, 1985		2b. HOUR 4:00p M
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 21, 1925	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		# UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN West		
13c. CITY OR TOWN Queen Anne Grasonville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 40 Prospect Bay Drive 21638					
14. FATHER'S NAME FIRST MIDDLE LAST Damas G. Vincent			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Benoit		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 11 577-12-1145		
17 INFORMANT West Patricia S. Vincent 40 Prospect Bay Drive Grasonville, Maryland 21638					
18. CAUSE OF DEATH (Enter only one cause for line 18a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiorgan System failure</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Adult Respiratory Distress Syndrome - 24 hr</i> (c) <i>Diffuse Intravascular Coagulation 24 hr</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Generalized Atherosclerosis, C.O.P.D.</i>					
19a. DATE OF OPERATION B-21-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abd. aortic aneurysm		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT <input type="checkbox"/> COLD <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (we) hospital attended the deceased from <i>21 August 1985</i> to <i>22 August 1985</i> , that (I) (we) last saw the deceased alive on <i>22 August 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE GARY M. Richardson, MD.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-22-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. Richardson, MD.			22e. ADDRESS 104 Forbes Street Annapolis, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA			25a. DATE OF REGISTRATION AUG 28 1985		
7557 Wisconsin Avenue Bethesda, Maryland 20814			25b. REGISTRAR'S SIGNATURE J. M. Davidson		

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1. The first part of the report is a general
description of the area. It is a large area
of land, mostly flat, with some hills in the
north. The climate is warm and humid, with
heavy rainfall throughout the year. The
population is small, and the economy is
based on agriculture. The main crops are
rice and sugarcane. There are some
small towns and villages, but most of the
population lives in small hamlets.

2. The second part of the report is a
description of the land. It is a large area
of land, mostly flat, with some hills in the
north. The climate is warm and humid, with
heavy rainfall throughout the year. The
population is small, and the economy is
based on agriculture. The main crops are
rice and sugarcane. There are some
small towns and villages, but most of the
population lives in small hamlets.

3. The third part of the report is a
description of the land. It is a large area
of land, mostly flat, with some hills in the
north. The climate is warm and humid, with
heavy rainfall throughout the year. The
population is small, and the economy is
based on agriculture. The main crops are
rice and sugarcane. There are some
small towns and villages, but most of the
population lives in small hamlets.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21489

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH M. VIRGIN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 11, 1985			2b. HOUR 8:00 PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV. 3, 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ARNOLD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 777 HARMONY AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. YARD MASTER	
12b. KIND OF BUSINESS OR INDUSTRY RAILROAD							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 777 HARMONY AVE 21012							
14. FATHER'S NAME FIRST MIDDLE LAST NICHOLAS VIRGIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA LIVINGSTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 715-12-3998		17. INFORMANT ADDRESS JOHN R. JORDAN (SAME AS 13)	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Atherosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 79 8-11 815			
22a. I certify that (i) (this hospital) attended the deceased from 8-6-85 to 8-11-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did not) view the body after death.							
22b. SIGNATURE Arnold Alexander MD				DEGREE MD		22c. DATE SIGNED 8-17-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD ALEXANDER				22e. ADDRESS RITCHIE HWY. ARNOCD MD. 21012			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE ANNE ARUNDEL MD	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME				ADDRESS 501 RITCHIE HWY SEVERNA PARK MD 21154		25a. DATE REC'D. BY REGISTRAR AUG 14 1985	
				25b. REGISTRAR'S SIGNATURE Jill Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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241059

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 19 shows any injury, or other traumatic event, the medical examiner must not file a notice of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		2. REG. NO.				21490							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
William		Walker						August 22 1985		3:45A			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
M		W		2 5 29		56 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
PENNSYLVANIA		U.S.N.				AnnArundel County, MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Laurel		64 South Paula Dr.		CARPENTER		Building							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		ANNEARUNDEL		LAUREL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		64 SOUTH PAULA DRIVE 20707					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
LAIRD M. WALKER		ELLA MARTIN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS							
YES		KOREAN		204-16-0687		VEDA WALKER		SAME AS #13E					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 11/13 19 84 to 8/22 19 85, that (1) (we) lost X saw the deceased alive on 6/24 19 85, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED X 8/22/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) X John MARGOUS		22e. ADDRESS X 14333 Laurel Drive Rd Ste 50708 Laurel, MD 20708											
23a. BURIAL, CREMATION, REMOVAL (RECEIVED) BURIAL		23b. DATE 8/24/85		23c. NAME OF CEMETERY OR CREMATORY ST. CALLISTAS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE KANE MCKEAN PA.							
24 FUNERAL DIRECTOR NAME Fleck F. H. Inc. 7601 SANDY SPRING Rd. LAUREL Md.		25a. DATE REC'D. BY REGISTRAR AUG 27 1985		25b. REGISTRAR'S SIGNATURE									

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219095

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) WILLIAM F WALKER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 2, 1985		2b. HOUR 400 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1901		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS (LAST BIRTHDAY)) 84 YES MONTHS DAYS HOURS MIN.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Coal Miner		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		13a. STREET ADDRESS / ZIP CODE 1629 Eton Way 21114		
14. FATHER'S NAME FIRST MIDDLE LAST James Walker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget McHale		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 160-05-1847		17. INFORMANT ADDRESS Jon St. Ledger same as 13c		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with Respiratory Failure</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 19, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>8/1/85</u> to <u>8/2/85</u> that (I) (we) last saw the deceased alive on <u>8/1/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
23a. SIGNATURE <u>Chackimcal V. Cyriac, M.D.</u>		23b. DEGREE MD		23c. ADDRESS 14 WELLHAM AVENUE, SUITE 101 GLEN BURNIE, MARYLAND 21061		
23d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKIMCAL V. CYRIAC, M.D.		23e. DATE Aug. 5, 1985		23f. NAME OF CEMETERY OR CREMATORY Mother of Sorrows Cem		
23g. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial		23h. DATE Aug. 5, 1985		23i. LOCATION CITY OR TOWN COUNTY STATE Greenfield Township, Penn.		
24. FUNERAL DIRECTOR NAME Beall Funeral Home		24b. ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25. DATE REC'D. BY REGISTRAR AUG 5 1985		
25. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		26. REGISTRAR'S NAME Julia Davidson-Randall				

MEDICAL CERTIFICATION

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



100% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
EDNA			MAY	WARD	AUGUST 29, 1985				8:30 A.M.
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
female	white		Jan 24, 1897		88		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MD	USA				ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		homemaker		own home				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MD		AA	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7985 Crilley RD 21061				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Howard		Eckhardt		Nora Lily					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		XXXXXXX		212/07/9664A Vernon J. Ward (son) Glen Burnie, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 26</u> 19 <u>85</u> to <u>Aug. 29</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Aug. 28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
CHARLES J. WU, M.D.		7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (RECORD)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		31 Aug 1985		Cedar Hill		Brooklyn Pk. AA MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home, Glen Burnie, MD		SEP 3 1985		J. Davidson-Randall					

MEDICAL CERTIFICATION

248076

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or either if a traumatic event, the medical examiner must be notified at once.

aropis



219062

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Pauline Olivia Waskey			2a. DATE OF DEATH MONTH 8 DAY 2 YEAR 1985			2b. HOUR 5¹⁵ A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 14 YEAR 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian-Severna Park 24 Truckhouse Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public School			
USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 338 Cedar Drive 21801			
14. FATHER'S NAME FIRST Samuel MIDDLE E. LAST Downing				15. MOTHER'S MAIDEN NAME FIRST Agnes MIDDLE F. LAST Darby							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-2439		17. INFORMANT ADDRESS Leonard C. Waskey 338 Cedar Dr. 21801							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral calcification DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 mos.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/1/85 to 8/2/85 , that (I) (was) lost saw the deceased alive on 7/1/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (was) did not) view the body after death.											
22b. SIGNATURE Margaret M. Mullins, MD										22c. DATE SIGNED 8/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET M MULLINS					22e. ADDRESS 1020 CAPE ST. CLARE RD. ANNAPOLIS MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/5/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. ADDRESS 4107 Wilkens Ave.					25a. DATE REC'D. BY REGISTRAR AUG 5 1985		25b. REGISTRAR'S SIGNATURE J. Davidson				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the head of the family should be notified of the death.

50015



COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

220080

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21494

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace H Webb			2a. DATE OF DEATH MONTH DAY YEAR 7 30 85			2b. HOUR 9:10 A.M.		
3 SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 16 1900		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10 CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Arundel Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
13a. STATE Md.		13b. COUNTY AA.		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Webb		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Barker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 212-10-8729		17 INFORMANT ADDRESS Mrs. Ruby Guerke, 2014 Gracie Dr., Finksburg, Md. 21048						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 10 YRS.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: DIABETES MELLITUS, PREVIOUS CVA								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)				
20d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		20f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21. I certify that (1) (this hospital) attended the deceased from 12-18-19-79 to 7-30-19-85 , that (1) (we) last saw the deceased alive on 7-12-19-85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.								
22a. SIGNATURE Dr. Edward S. Beck				22b. ADDRESS 1616 Forest Drive, Annapolis, Md. 21403		22c. DATE SIGNED 7/30/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/1/85		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc., 6500 York Rd. 21212				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 6 1985				

256038

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary H Weber			2a. DATE OF DEATH MONTH DAY YEAR 8 25 85			2b. HOUR P M 12:50 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 13 24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook	
12b. KIND OF BUSINESS OR INDUSTRY Deli Store							
13a. STATE Md.		13b. COUNTY A. Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 8-E Bens Drive 21403							
14. FATHER'S NAME FIRST MIDDLE LAST Hubert Hurd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bobbie Cantwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-4841		17. INFORMANT ADDRESS Mr. Pete Weber - Same as #13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Bowel ischemia Lung cancer (large cell)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —			
22a. I certify that (I) (this hospital) attended the deceased from 19 83 to 8/25 19 85, that (I) (we) last saw the deceased alive on 8/25 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS Anne Arundel Genl Hosp. Annapolis 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/25/85		23c. NAME OF CEMETERY OR CREMATORY —		23d. LOCATION CITY OR TOWN COUNTY STATE — — — — —	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR AUG 29 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

828008

21

252067

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET WEST			2a. DATE OF DEATH MONTH DAY YEAR 8 25 85		2b. HOUR 12:15 AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 24 33		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 52		IF UNDER 1 YEAR MONTHS DAYS 8 25		IF UNDER 24 HRS. HOURS MIN. 12 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec'y		12b. KIND OF BUSINESS OR INDUSTRY State			
13a. STATE Md.		13b. COUNTY A. Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 706 Bayridge Ave. 21403			
14. FATHER'S NAME FIRST MIDDLE LAST John Grindle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-56-1954		17. INFORMANT ADDRESS Mr. Thomas West - Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Myeloma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from Dec. 19 84 to Aug 25, 19 85 that (1) we last saw the deceased alive on Aug 25, 19 85 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above; (1) <u>we</u> did not view the body after death.											
22b. SIGNATURE Barry P. Nathanson MD				DEGREE FOR DR. STUART SEWICK ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/25/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY P. NATHANSON MD				22e. ADDRESS 51 FRANKLIN ST. ANNAP MD 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/25/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit period. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

234038

1. DECEASED NAME (TYPE OR PRINT) Kathryn Anna Whitlock			2a. DATE OF DEATH MONTH DAY YEAR 8 10 85			2b. HOUR 9:00 ^a								
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 4 90		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS HOURS MIN. 00 00				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH Odenton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21113 491 Higgins Dr. Odenton, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.			13c. CITY OR TOWN Odenton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 491 Higgins Dr. 21113		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 159-20-7511			17. INFORMANT Odenton, Md. 21113 Robert H. Kienzle 491 Higgins Dr.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (c) benign nephrosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I, (this hospital)) attended the deceased from 7/1 19 85 , to 8/10 19 85 , that (I, (we)) lost view the deceased above (I, (we)) (did, (did not)) view the body after death.														
23a. SIGNATURE [Signature]						23b. DEGREE MD			23c. DATE SIGNED 8/10/85					
23d. PHYSICIAN'S NAME (TYPE OR PRINT) [Name]						23e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/12/85			23c. NAME OF CEMETERY OR CREMATORY Westview Crematory			23d. LOCATION CITY OR TOWN COUNTY Catonnsville Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md. 21061						25a. DATE REC'D. BY REGISTRAR AUG 14 1985			25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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246098

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
WILLIAM Llewellyn WILLETT SR				AUGUST 27, 1985		1259 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR 7 8 21		64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Mechanic		Heating			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland		A.A.		Riviera Bch YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		210 Carvel Road		21122	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST William W. Willett		FIRST MIDDLE LAST Kate E. Anthony							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
Yes		WW II		212-14-2637		Phyllis L. Willett		Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>79</u> , to _____, 19 _____, that (I) (we) last saw the deceased alive on <u>7/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Glenn F. Robbins M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D.				22e. ADDRESS 1404 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		8/30/85		Loudon Park Cemetery		Balto Md			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy Balto Md				25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

MEDICAL CERTIFICATION

1

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

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completely filled in by the funeral director, page 2 and 3 should be filed with the death certificate. Page 1 and 2 should be filed with the death certificate.

The medical examiner must be notified at once.

7

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

REPORT OF THE SURVEYOR
ON THE LANDS OF THE UNITED STATES
IN THE STATE OF TEXAS

235143

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21499

1. DECEASED NAME (TYPE OR PRINT) DOROTHY T. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 8 20 85			2b. HOUR M. AM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YR 12 15 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 524 First Street 21403	
14. FATHER'S NAME FIRST MIDDLE LAST ALLEN TURNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL M. JOHNSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Annapolis, Md. 21403 STEPHANIE JONES 524 First Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Septic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE OR CONDITION GIVEN IN PART 1: a Resp failure Adenocarcinoma Colon									
19a. DATE OF OPERATION 8-20-85				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:30 P.M. 8 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 713 85 to 8-20 85					
22a. I certify that (I) (this hospital) attended the deceased from 8-20 85 to 8-20 85 , that (I) (we) lost saw the deceased alive on 8-20 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Michael J. Latenta MD				DEGREE MD				22c. DATE SIGNED 8/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. Latenta MD				22e. ADDRESS 703 GIDDINGS AVE ANNAPOLIS MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-24-1985		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21500

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris Anna Rose Wockenfuss			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 9, 1985		2b. HOUR 1020 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1921		
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STREET ADDRESS / ZIP CODE 564 West Drive 21146				
13b. COUNTY AnneArundel		13c. CITY OR TOWN SevernaPark		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William A. Scheidegger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Heil				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None 217.20.3234		17. INFORMANT ADDRESS Linda Broome Daughter Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hemorrhagic Shock</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 days</u> <u>14 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Recent myocardial infarction</u>						
19a. DATE OF OPERATION <u>7/28/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding gastric ulcer</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> 19 <u>83</u> to <u>8/10</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>8/9</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Constantine J. Patussis</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>8/10/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONSTANTINE J. PATUSSIS, M.D.		22e. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.		24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home, Glen Burnie, Md.				
25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

SAITON

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UNITED STATES

238094

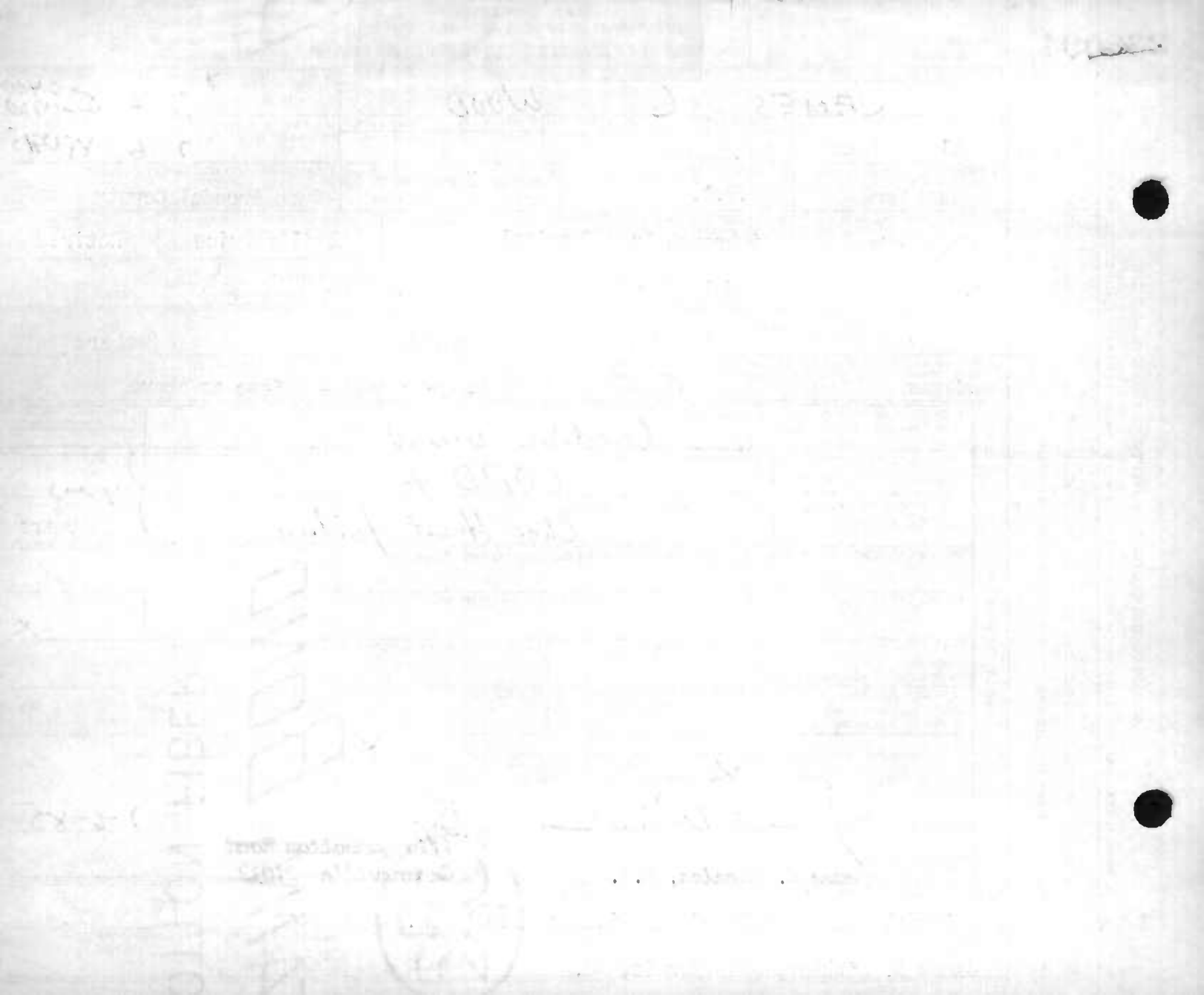
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21301 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES C WOOD										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR 7 6 1985 2400	
3. SEX Male		4. RACE Cauca		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1903		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 82 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR 7 6 1985 0545		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Ft. Meade			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service			12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 491 Greenwood		21113	
14. FATHER'S NAME FIRST MIDDLE LAST N/A Wood						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Hubbard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) unknown			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2			17. INFORMANT ADDRESS Beverly Wood - Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. COPD + (b) Chr. Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) 20 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE James S. Wheeler M.D.						TITLE (SPECIFY) Dep			DATE SIGNED 7-6-85		
EXAMINER'S NAME (TYPE OR PRINT) James S. Wheeler, M.D.						ADDRESS 1716 Gumbottom Road Crownsville 21032					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8 July 85		23c. NAME OF CEMETERY OR CREMATORY Nichols Bethel Cem.		23d. LOCATION CITY OR TOWN Odenton		COUNTY STATE AA Md.	
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Md.						25a. DATE REC'D. BY REGISTRAR AUG 20 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendall		

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



232125

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21502

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
FIRST MIDDLE LAST ROSA DEE WRIGHT			MONTH DAY YEAR 8-14-85			12:15 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS			
FEMALE		CAUC.		MONTH DAY YEAR 3-19-06		79 YRS.		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NEW MEXICO		USA				A.A.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS		A.A.H.H.				HOMEMAKER		HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS			13d. ZIP CODE		
13a. STATE CITY OR TOWN MD. AA Crowsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			FAIRFIELD Loop Rd.			21032		
14. FATHER'S NAME (TYPE OR PRINT)			15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
GAYLE			MARGARET			NO			056-01-7006		
17. INFORMANT			17a. ADDRESS			17b. CITY OR TOWN			17c. STATE		
GAYLE N. Weight			11609 GEORGETOWN CT.			POTOMAC, MD.			20854		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>M.I.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>OVA</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>8/14</u> 19 <u>85</u> , to <u>present</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<u>Wm. J. Dabbs</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
DABBS			103 Giddings, Annapolis								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
CREMATION			8/15/85		CEDAR Hill		SUITLAND P.G. MD.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Taylor Funeral Chapel			Annapolis, Md			AUG 16 1985		<u>Davidson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

